Health History

Name _____ Date of Birth _____ Today's Date _____

Dental History

1. Reason for visit: _____
2. When was your last dental visit? _____
3. How often do you brush your teeth? _____
4. What texture toothbrush do you use? □ Soft □ Medium □Hard
5. Do your gums bleed while brushing? YES NO
6. Do your gums bleed when flossing? YES NO
7. Do you feel pain to any of your teeth when brushing or flossing them? YES NO
8. Are your teeth sensitive to sensitive to (circle all that apply) HOT COLD SWEET SOUR
9. Any area in particular? UPPER LOWER RIGHT LEFT
10. Have you noticed any loosening of your teeth? YES NO
11. Does food tend to become caught between your teeth? YES NO
12. Have you ever experienced any of the following in your jaw:
    a. Clicking? YES NO
    b. Pain (joint, ear, side of face)? YES NO
    c. Difficulty in opening or closing? YES NO
    d. Difficulty in chewing? YES NO
13. Have you had any head, neck or jaw injuries? YES NO
14. Do you have frequent headaches? YES NO
15. Do you clench or grind your teeth while awake or asleep? YES NO
16. Do you bit your lips or cheeks frequently? YES NO
17. Have you ever had:
    a. Orthodontic treatment or braces? YES NO
    b. Oral surgery? YES NO
    c. Gum treatment? YES NO
    d. Your teeth ground or the bite adjusted? YES NO
    e. Worn a bite plate or other appliance? YES NO
18. Are you happy with your smile? YES NO
19. Have you ever had an upsetting experience in the dental office? YES NO
20. Is there anything about having dental treatment that bothers you? YES NO
21. Do you take any medications that cause dry mouth (reduced/no saliva) YES NO

TO BE COMPLETED BY DENTAL PERSONNEL

SUMMARY OF DENTAL HISTORY

SUMMARY OF MEDICAL HISTORY

Medical History

Physician Name: _____

Phone: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

1. Are you in good health? **YES NO**

2. Have there been any changes in your in your general health within the past year? **YES NO**

3. Date of your last physical exam: _____

4. Are you now under the care of a physician? **YES NO**

5. Have you ever been hospitalized for any surgical operation or serious illness? **YES NO**
   Please explain: _____

6. Are you taking any medications? **YES NO**
   Please list (include non-prescription): _____
   _____

7. Have you taken Fen-Phen/Redux? **YES NO**

8. Have you had any abnormal bleeding? **YES NO**

9. Do you bruise easily? **YES NO**

10. Have you ever required a blood transfusion? **YES NO**
    transfusion? **YES NO**

11. Have you had recent weight loss? **YES NO**

12. Do you have a persisitent cough or throat clearing not associated with a known Illness lasting more than 3 weeks? **YES NO**

13. Do you use tobacco? **YES NO**

14. Do you use cocaine or other drugs? **YES NO**

15. Are you wearing contact lenses? **YES NO**

16. Do you have any disease, condition or problem not listed above that you think we should know about?
    _____
    _____
    _____

Are you ALLERGIC to or have you had REACTIONS to:

1. Local anesthetics like Novocaine? **YES NO**
2. Penicillin? **YES NO**
3. Sulfa Drugs? **YES NO**
4. Barbiturates, sedatives, or sleeping pills? **YES NO**
5. Aspirin? **YES NO**
6. Iodine? **YES NO**
7. Other? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

Signature or patient or guardian **Date**

Women Only:

1. Are you pregnant or think you may be pregnant? **YES NO**
2. Are you nursing? **YES NO**
3. Are you taking birth control pills? **YES NO**

DO YOU HAVE/EVER HAD THE FOLLOWING:

1. Rheumatic heart disease/fever? **YES NO**
2. Scarlet fever? **YES NO**
3. Heart trouble or heart murmur? **YES NO**
4. Heart attack or angina? **YES NO**
   a. Do you have pain in your chest upon exertion? **YES NO**
   b. Are you ever short of breath after mild exercise? **YES NO**
   c. Do your ankles swell? **YES NO**
   d. Do you get short of breath when you lie down? **YES NO**
   e. Do you require extra pillows when you sleep? **YES NO**
5. Pacemaker? **YES NO**
6. Heart surgery? **YES NO**
7. High blood pressure? **YES NO**
8. Low blood pressure? **YES NO**
9. Hepatitis, jaundice or liver disease? **YES NO**
10. Stroke? **YES NO**
11. Sinus Trouble? **YES NO**
12. Lung or breathing problems? **YES NO**
13. Asthma or hay fever? **YES NO**
14. Hives or skin rash? **YES NO**
15. Fainting spells or seizures? **YES NO**
16. Diabetes? **YES NO**
17. AIDS or HIV infection? **YES NO**
18. Thyroid problems? **YES NO**
19. Allergies? **YES NO**
20. Arthritis or rheumatism? **YES NO**
21. Joint replacement or implant? **YES NO**
22. Stomach ulcer? **YES NO**
23. Kidney trouble? **YES NO**
24. Tuberculosis? **YES NO**
25. Persistent Cough? **YES NO**
26. Cough that produces blood? **YES NO**
27. Cancer? **YES NO**
28. Sexually transmitted disease? **YES NO**
29. Epilepsy? **YES NO**
30. Anemia? **YES NO**