

Health History

NAME _____ BIRTHDATE _____ TODAY'S DATE _____

A Dental History

1. Reason for visit: _____
 2. When was your last dental visit? _____
 3. How often do you brush your teeth? _____
 4. What texture brush do you use? Soft Medium Hard
- | | YES | NO | | YES | NO |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 5. Do your gums bleed while brushing? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you had any head, neck, or jaw injuries? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do your gums bleed when flossing? | <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you feel pain to any of your teeth when brushing or flossing them? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Do you clench or grind your teeth while awake or asleep? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids? | <input type="checkbox"/> | <input type="checkbox"/> | 16. Do you bite your lips or cheeks frequently? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you noticed any loosening of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | 17. Have you ever had: <ol style="list-style-type: none"> a. Orthodontic treatment (braces)? <input type="checkbox"/> <input type="checkbox"/> b. Oral surgery? <input type="checkbox"/> <input type="checkbox"/> c. Gum treatment? <input type="checkbox"/> <input type="checkbox"/> d. Your teeth ground or the bite adjusted? <input type="checkbox"/> <input type="checkbox"/> e. Worn a bite plane or other appliance? <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Does food tend to become caught between your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | 18. Are you satisfied with the appearance of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you have any sores or lumps in or near your mouth? | <input type="checkbox"/> | <input type="checkbox"/> | 19. Have you ever had an upsetting experience in the dental office? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever experienced any of the following problems in your jaw? <ol style="list-style-type: none"> a. Clicking? <input type="checkbox"/> <input type="checkbox"/> b. Pain (joint, ear, side of face)? <input type="checkbox"/> <input type="checkbox"/> c. Difficulty in opening or closing? <input type="checkbox"/> <input type="checkbox"/> d. Difficulty in chewing? <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 20. Is there anything about having dental treatment that bothers you? | <input type="checkbox"/> | <input type="checkbox"/> |

B Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a 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.

- | | YES | NO | | YES | NO |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Are you in good health? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Have you had any abnormal bleeding? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have there been any changes in your general health within the past year? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you bruise easily? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Date of your last physical exam: _____ | | | 11. Have you ever required a blood transfusion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Physician's name _____
Address _____
Phone No. _____ | | | 12. Have you had a recent weight loss? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you now under the care of a physician? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever been hospitalized for any surgical operation or serious illness? Please explain. _____ | <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you use tobacco? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you taking any medicine(s) including non-prescription medicine? If yes, what medicine(s) are you taking? _____ | <input type="checkbox"/> | <input type="checkbox"/> | 15. Do you use alcohol or cocaine or other drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever taken Fen-Phen/Redux? | <input type="checkbox"/> | <input type="checkbox"/> | 16. Are you wearing contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 17. Do you have any disease, condition or problem not listed above that you think I should know about? | <input type="checkbox"/> | <input type="checkbox"/> |
- Women Only:**
1. Are you pregnant or think you may be pregnant?
 2. Are you nursing?
 3. Are you taking birth control pills?

(OVER)



Medical History Continued...

YES NO

Are you allergic to or have you had reactions to:

- 1. Local anesthetics like novocaine? YES NO
- 2. Penicillin or other antibiotics? 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? YES NO

Do you have or have you ever had the following:

- 1. Rheumatic heart disease or rheumatic fever? YES NO
- 2. Scarlet fever? YES NO
- 3. Heart defect or heart murmur? YES NO
- 4. Heart trouble, 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

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
- 31. Leukemia? YES NO
- 32. Glaucoma? YES NO

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 OF PATIENT, PARENT, or GUARDIAN

DATE

For Completion By The Dentist:

SUMMARY OF DENTAL HISTORY

SUMMARY OF MEDICAL HISTORY

MEDICAL HISTORY UPDATE:

INITIALS:

DATE	COMMENTS	PATIENT	DENTIST	HYGIENIST