Health 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 you will receive. Thank you for answering the following questions.

Patient Name _____ DOB _____ Date:_____

Physician's Name _____ Phone _____ Date of Last Physical/Exam _____

Have you recently been hospitalized? If so, reason for hospitalization: _____

Please circle "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	Yes	No	Emphysema	Yes	No	Radiation Treatment	Yes	No
Anemia	Yes	No	Epilepsy	Yes	No	Respiratory Disease	Yes	No
Angina	Yes	No	Fainting or Seizures	Yes	No	Rheumatic Fever	Yes	No
Arthritis, Rheumatism	Yes	No	Fen-Phen/Redux	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valves	Yes	No	Glaucoma	Yes	No	Shortness of Breath	Yes	No
Artificial Joints	Yes	No	Hayfever	Yes	No	Sickle Cell Anemia	Yes	No
Asthma	Yes	No	Headaches	Yes	No	Sinus Trouble	Yes	No
Autoimmune Disease	Yes	No	Heart Murmur	Yes	No	Skin Rash	Yes	No
Back Problems	Yes	No	Heart Disease	Yes	No	Special Diet	Yes	No
Bisphosphate	Yes	No	Hepatitis Type _____	Yes	No	Stents or Ports	Yes	No
Bleeding abnormally, with extractions or surgery	Yes	No	Herpes	Yes	No	Stomach Troubles	Yes	No
			High Blood Pressure	Yes	No	Stroke	Yes	No
Blood Disease	Yes	No	Jaundice	Yes	No	Swollen Feet or Ankles	Yes	No
Cancer	Yes	No	Jaw Pain	Yes	No	Swollen Neck Glands	Yes	No
Chemical Dependency	Yes	No	Kidney Disease	Yes	No	Thyroid Problems	Yes	No
Chemotherapy	Yes	No	Leukemia	Yes	No	Tonsillitis	Yes	No
Chest Pain	Yes	No	Liver Disease	Yes	No	Tuberculosis	Yes	No
Circulatory Problems	Yes	No	Low Blood Pressure	Yes	No	Tumor or growth on head or neck	Yes	No
Congenital Heart Lesions	Yes	No	Lupus	Yes	No			
Cortisone Treatments	Yes	No	Mitral Valve Prolapse	Yes	No	Ulcer	Yes	No
Cough, persistent or bloody	Yes	No	Multiple Sclerosis	Yes	No	Venereal Disease	Yes	No
Diabetes	Yes	No	Nervous Problems	Yes	No	Weight Loss, unexplained	Yes	No
If yes, are you insulin dependent?	Yes	No	Osteoporosis	Yes	No	Have you ever needed pre-medication?	Yes	No
			Pacemaker	Yes	No			
Do you wear contact lenses?	Yes	No	Psychiatric Care	Yes	No			

Have you ever had a serious illness not listed above? ❑ Yes ❑ No If yes, please explain:_____

Comments:_____

Are you taking or have you ever taken medications for osteoporosis? ❑ Yes ❑ No If yes, please list: _____

_____

Women:

Are you pregnant? Yes No Due Date: _____

Taking birth control? Yes No

Are you nursing? Yes No

Medications

List any medications you are currently taking and the correlating diagnosis. Including herbal supplements, vitamins and all over-the-counter medication.

Pharmacy Name _____

Phone (____) _____

_____

_____

Dental History

Burning sensation on tongue	Yes	No
Chew on one side of mouth	Yes	No
Cigarette, pipe, cigar smoking	Yes	No
Clicking or popping jaw	Yes	No
Dry mouth	Yes	No
Grinding teeth	Yes	No
Gums swollen or tender	Yes	No
Jaw pain or tiredness	Yes	No
Pain around ear	Yes	No
Periodontal treatment	Yes	No
Sores or growths in mouth	Yes	No

Allergies

Aspirin	Yes	No
Barbiturates (Sleeping pills)	Yes	No
Codeine	Yes	No
Iodine	Yes	No
Latex	Yes	No
Local Anesthetic	Yes	No
Penicillin	Yes	No
Sulfa	Yes	No

Other: _____

_____

_____

_____

Are you interested in whitening or straightening your teeth? ❑ Yes ❑ No

Signature _____ Date _____