

HEALTH HISTORY :

Correct answers to the following questions will allow your dental team to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name _____ Birthdate _____ Age _____

Why are you now seeking dental treatment? _____
 Are you currently in pain? _____

Please answer each question. Check yes or no. If in doubt, leave blank.

	YES	NO
1. Your current physical health is <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		
2. Are you under the care of a physician?	Y	N
If so, what is the condition being treated?		
3. Have you ever been hospitalized or had a serious illness?	Y	N
if yes, Explain	Y	N
5. (Women) Are you pregnant? If yes, give due date	Y	N
6. Do you use tobacco in any form? If yes, how much?	Y	N
7. DO you consume more than 2 alcoholic drinks per day?	Y	N
8. Do you need to be premedicated before dental treatment?	Y	N

DO YOU CURRENTLY HAVE OR HAD HISTORY OF THE FOLLOWING?

Please check yes or no to the following questions DO NOT LEAVE BLANK!

GENERAL

Swollen Extremities	Y	N
Tire easily, weakness	Y	N
Marked weight change	Y	N
Night sweats	Y	N
Persistent fever	Y	N

SKIN

Eruptions (rash) hives	Y	N
Change in skin color	Y	N

EYES

Visual change	Y	N
Glaucoma	Y	N

EARS

Loss of hearing	Y	N
Ringing in ears	Y	N

NOSE

Frequent nosebleeds	Y	N
Sinus problems	Y	N

THROAT

Soreness/hoarseness	Y	N
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NERVOUS SYSTEM

Alcohol/Drug abuse	Y	N
Stroke	Y	N
Headaches	Y	N
Convulsions/Epilepsy/Seizures	Y	N
Numbness/tingling	Y	N
Dizziness/fainting	Y	N
Psychiatric treatment	Y	N

Tuberculosis (TB)	Y	N
Emphysema	Y	N
Asthma/hay fever	Y	N
Persistent cough	Y	N
Sputum production (phlegm)	Y	N
Cough up blood sputum	Y	N

ENDOCRINE

Diabetes	Y	N
Family history of diabetes	Y	N
Thyroid condition/goiter	Y	N
Other	Y	N

HEART/BLOOD VESSELS

Stroke	Y	N
Rheumatic fever/Scarlet fever	Y	N
Heart murmur	Y	N
Chest pain/discomfort	Y	N
Heart attack/trouble	Y	N
Shortness of breath	Y	N
Swelling of ankles	Y	N
High blood pressure	Y	N
Low blood pressure	Y	N
Congenital heart disease	Y	N
Mitral valve prolapse	Y	N
Artificial heart valve	Y	N
Pacemaker	Y	N
Heart surgery	Y	N
Other	Y	N

BONE/MUSCLES

Arthritis/rheumatism	Y	N
Artificial joints/limbs	Y	N

DIGESTIVE SYSTEM

Hepatitis	Y	N
Jaundice	Y	N
Ulcers	Y	N
Change in appetite	Y	N
Black, bloody or pale stools	Y	N

URINARY

Kidney disease	Y	N
Increase in frequency of urination during the night	Y	N
Burning on urination	Y	N
Urethral discharge	Y	N
Bloody urine	Y	N
Venereal disease	Y	N
Difficulty breathing while lying down ..	Y	N

BLOOD

Hemophilia/Abnormal bleeding Y N
Bruise easily Y N
Anemia Y N
Blood transfusion Y N

OTHER

Radiation therapy Y N
Chemotherapy Y N
Tumors or growths Y N
Cancer/Type Y N
HIV+ Y N
AIDS Y N
Have you been tested for HIV Y N

New mothers are you nursing?

Latex allergy..... Y N
Mental retardation Y N
Cortisone Medication ... Y N
Any Metallic allergy ... Y N
Sickle Cell Disease Y N
Cold Sores Y N
Herpes Y N
Organ transplant Y N

Do you prefer IV sedation (going to sleep) for dental treatment? Y N
Have you ever had nitrous oxide (Laughing Gas) administered during dental treatment? Y N
Was it a pleasant experience? Y N

9. Are you ALLERGIC to or have you ever experienced any reaction any reaction to the following?

Local anesthetics (e.g. novocaine) Y N
Barbiturates/sedatives/sleeping pills Y N
Penicillin Y N
Erythromycin Y N
Tetracycline Y N
Codeine Y N
Aspirin Y N
Sulfa drugs Y N
Other allergies Y N

10. Are you now taking any of the following?

Antibiotics/sulfa drugs Y N
Blood thinners Y N
Blood pressure medication Y N
Thyroid medicine Y N
Nitroglycerin Y N
Cortisone/steroids Y N
Antihistamines/allergy drugs/ Y N
Cold remedies Y N
Tranquilizers Y N
Insulin/other diabetes drugs Y N
Recreational drugs/Illegal drugs Y N
Digitalis/other heart medications Y N
Aspirin Y N
Nitroglycerin Y N
Other Medication _____

If yes to any of the above, list name of medication and dosage below:

- 1. _____
2. _____
3. _____

Are you under any unusual stress at home or work? _____

11. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so explain _____

12. Physician's Name _____ Date of last visit _____

13. Have you ever had any serious trouble (bad experiences) associated with previous dental treatment? _____

14. Does dental treatment make you nervous? NO ___ Slightly ___ Moderately ___ Extremely ___

15. Date of last dental visit _____

16. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth) ? _____

17. Do you have or have you ever had any of the following?

MOUTH

Bleeding, sore gums Y N
Unpleasant taste/bad breathe ... Y N
Burning tongue/lips Y N
Frequent blisters, lips/mouth .. Y N
Swelling/lumps in mouth Y N
Orthodontic treatment (braces) Y N
Biting cheeks/lips Y N
Clicking/popping jaw Y N
Difficulty opening or closing Y N
Would you like to prevent dentures Y N

TEETH

Loose teeth..... Y N
Sensitive to hot .. Y N
Sensitive to cold Y N
Sensitive to sweets Y N
Sensitive to biting Y N
Food impaction Y N
Clenching/grinding Y N
Shifting of teeth Y N
Change in bite Y N
Are your teeth: chipped ___ protruding ___ hidden ___

Do you like the appearance of your teeth?..... Y N
Are your teeth all in alignment (Straight) ?..... Y N
Do you have spaces that you don't like? Y N
Do you like the color of your teeth? Y N
Do you like the shape of your teeth? Y N
Do you like the way your teeth come together? Y N
Are there old fillings or dental work that you do not like looking at? Y N
Do you gag easily? Y N

ORAL HYGIENE

Do you use the following
Brush Y N
Dental floss Y N
Fluoride rinse Y N
Water irrigator Y N
Other _____

How would you rate your smile on a scale of 1-10 (10 being the highest)? _____
What would you like to change the most in the appearance of your teeth? _____
How often do you brush _____
Brush is: Soft Medium Hard
Type of brush _____

To the best of knowledge, all of the preceding answers are true and correct.

If I ever have any change in my health or change my medication, I will inform the dentist at the next appointment.

Signature of Patient _____
Parent, or Guardian _____ Date _____