HEALTH HISTORY

Name _____ Date of Birth _____ Age _____

Why are you seeking dental treatment? _____

Please answer each question. Check yes or no. If in doubt, leave blank.	**Yes**	**No**
1. Are you in good health now?	☐	☐
2. Are you now under the care of a physician?	☐	☐
If so, what is the condition being treated? _____		
3. Name of physician _____		
4. Have you ever been hospitalized or had a serious illness?	☐	☐
If yes, explain _____		
5. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously?	☐	☐
6. (Women) Are you pregnant? If so, due date _____ Nursing? _____	☐	☐
7. Do you use tobacco in any form? If yes, how much? _____	☐	☐
8. Do you use alcoholic beverages (more than 2 drinks per day)?	☐	☐
9. Is there any medical condition or history of treatment that might affect your dental treatment?	☐	☐
If so what? _____		
10. Are you satisfied with the appearance and function of your teeth?	☐	☐

Please Circle any of the following you have or have had in the past:

GENERAL
Tire easily, weakness
Marked weight change
Night sweats

SKIN
Eruptions (rash), hives
Change in skin color

EYES
Visual change
Glaucoma

EARS
Loss of hearing
Ringing in ears

NOSE
Frequent nosebleeds
Sinus problems

NERVOUS SYSTEM
Stroke
Headaches
Convulsions/epilepsy
Numbness/tingling
Dizziness/fainting
Psychiatric Treatment

RESPIRATORY
Tuberculosis
Difficulty breathing
Emphysema
Asthma/hay fever
Persistent cough

ENDOCRINE
Diabetes
Family history of diabetes
Thyroid condition/goiter
Other _____

HEART/BLOOD VESSELS
Rheumatic fever
Heart murmur
Chest pain/discomfort
Heart attack/trouble
Shortness of breath
Swelling of ankles
High blood pressure
Congenital heart disease
Artificial heart valve
Pacemaker
Heart surgery
Other _____

BONE/MUSCLES
Arthritis/rheumatism
Artificial joints
Osteoporosis

DIGESTIVE SYSTEM
Hepatitis
Jaundice
Ulcers

URINARY
Kidney disease
Increase in frequency of urination (night)
Burning on urination
Venereal disease

BLOOD
Bruise easily
Anemia
Blood transfusion

OTHER
Radiation therapy
Tumors or growths
Cancer
AIDS/HIV

MEDICAL HISTORY IN OFFICE NOTES

DATE	CHANGES – CONTRAINDICATIONS	INITIALS

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

	Yes	No
Local anesthetics (e.g. novocaine)	☐	☐
Barbiturates/sedatives/sleeping pills	☐	☐
Penicillin/other antibiotics	☐	☐
Aspirin or codeine	☐	☐
Sulfa drugs	☐	☐
Latex allergy	☐	☐
Other allergies _____	☐	☐

12. Are you taking any of the following?

	Yes	No		Yes	No		Yes	No
Antibiotics/sulfa drugs	☐	☐	Antihistamines/allergy drugs, cold remedies	☐	☐	Digitalis/other heart medicines	☐	☐
Blood thinners	☐	☐	Anti depressants	☐	☐	Nitroglycerin	☐	☐
Blood pressure medicines	☐	☐	Insulin/other diabetes drugs	☐	☐	Aspirin	☐	☐
Thyroid medicine	☐	☐	Recreational drugs	☐	☐	Birth control	☐	☐
Cortisone/steroids	☐	☐				Herbal supplements/ other	☐	☐

List names of medicine and dosage below:

1. _____ 2. _____
3. _____ 4. _____

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

_____

14. Have you ever had any serious trouble complications associated with previous dental treatment? If so, explain:

_____

15. Does dental treatment make you nervous? No ___ Slightly ___ Moderately ___ Extremely ___
16. Date of last dental visit _____ last dental cleaning _____ how often _____
    Date of last dental x-rays _____
17. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)?_____
    If so, when? _____
18. Name of your previous dentist _____ Phone _____
    Address _____ How Long? _____

Please Circle the following you have or have had in the past 6 months:

MOUTH	**TEETH**
Bleeding, sore gums	Bad reaction to dental anesthetic, numbing
Unpleasant taste/bad breath	Loose teeth
Burning tongue/lips	Sensitive to hot
Frequent blisters, lips/mouth	Sensitive to cold
Swelling/lumps in mouth	Sensitive to sweets
Clicking/popping jaw/clenching/grinding	Food impaction
Difficulty opening or closing jaw	Change in bite
Headache/earache/neck pain	Numbness

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or change in my medication, I will inform the dentist at the next appointment.

_____ _____

Signature of Patient, Parent or Guardian Date