

HEALTH HISTORY

Patient Name _____

Describe your general health:

Excellent Good Fair Poor

Are you under the care of a physician or health care provider? Yes No

Have you been advised to take antibiotics before dental care? Yes No

MEDICAL ALERTS

HAVE YOU EVER HAD THE FOLLOWING: YES NO

YES NO

Allergic or adverse reaction to:

aspirin, ibuprofen, acetaminophen _____	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder _____	<input type="checkbox"/>	<input type="checkbox"/>
penicillin or other antibiotics _____	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema _____	<input type="checkbox"/>	<input type="checkbox"/>
codeine or other narcotics _____	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
local anesthetic _____	<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
fluoride _____	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
metals _____	<input type="checkbox"/>	<input type="checkbox"/>	Head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
latex or other dental materials _____	<input type="checkbox"/>	<input type="checkbox"/>	Hearing aid _____	<input type="checkbox"/>	<input type="checkbox"/>
any other medications _____	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (type _____) _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems			High cholesterol _____	<input type="checkbox"/>	<input type="checkbox"/>
heart murmur _____	<input type="checkbox"/>	<input type="checkbox"/>	Hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
rheumatic fever _____	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
heart surgery _____	<input type="checkbox"/>	<input type="checkbox"/>	Joint replacement _____	<input type="checkbox"/>	<input type="checkbox"/>
heart valve _____	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	Lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol or drug abuse _____	<input type="checkbox"/>	<input type="checkbox"/>	Mental health problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	Neurological problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis/osteopenia _____	<input type="checkbox"/>	<input type="checkbox"/>
Asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	Smoke or tobacco use _____	<input type="checkbox"/>	<input type="checkbox"/>
Breathing/Sleep problems _____	<input type="checkbox"/>	<input type="checkbox"/>	Stroke _____	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Tumor _____	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid (type _____) _____	<input type="checkbox"/>	<input type="checkbox"/>
chemotherapy _____	<input type="checkbox"/>	<input type="checkbox"/>	Viral infections (i.e. cold sores) _____	<input type="checkbox"/>	<input type="checkbox"/>
radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers _____	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety / Panic Attacks _____	<input type="checkbox"/>	<input type="checkbox"/>	Female		
Diabetes (type _____) _____	<input type="checkbox"/>	<input type="checkbox"/>	Taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
Digestive disorders (i.e. gastric reflux) _____	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>

List any medications, supplements, and or vitamins you are currently taking:

Drug	Reason	Drug	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comments: _____

Patient Signature _____ Dr. Initials _____ Date _____

DENTAL HISTORY

Immediate concern _____

Date and type of last dental visit _____

How would you rate the condition of your mouth? Excellent Good Fair Poor

PERSONAL HISTORY

YES NO

- How anxious are you about dental treatment on a scale of 0 (not at all) to 10 (very) _____
- Have you ever had an unfavorable dental experience? _____
- Have you ever had complications from past dental treatment? _____
- Have you ever had trouble getting numb or reactions to local anesthetic? _____
- Did you ever have braces, orthodontic treatment or had your bite adjusted? _____
- Have you had any teeth removed? _____

SMILE CHARACTERISTICS

- Is there anything about the appearance of your teeth that you would like to change? _____
- Are you self conscious about your teeth or smile? _____
- Have you been disappointed with the appearance of previous dental work? _____
- Have you ever whitened (bleached) your teeth? _____

BITE AND JAW JOINT

- Do you have any problems chewing gum? _____
- Do you/would you have any problems chewing bagels or other hard food? _____
- Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____
- Are your teeth crowding or developing spaces? _____
- Do you have more than one bite or do you clench or squeeze to make your teeth fit together? _____
- Do you clinch or grind your teeth or wake up with an awareness of your teeth? _____
- Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____
- Do you have tension headaches or sore teeth? _____
- Do you wear or have you ever worn a bite appliance? _____

TOOTH STRUCTURE

- Have you had any cavities in the past 3 years? _____
- Do you have a dry mouth? _____
- Are any teeth sensitive to hot, cold, biting or sweets? _____
- Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? _____
- Do you feel or notice any holes in your teeth? _____
- Do you avoid brushing any part of your mouth? _____

GUM AND BONE

- Have you ever been diagnosed or treated for periodontal (gum) disease? _____
- Is there anyone with a history of periodontal disease in your family? _____
- Have you ever experienced gum recession? _____
- Do your gums bleed when brushing, flossing or eating? _____
- Are your teeth becoming loose? _____
- Have you ever noticed an unpleasant taste or odor in your mouth? _____

Comments: _____

Date _____

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Patient Name _____

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Excellent Good Fair Poor

Are you under the care of a physician or health care provider? Yes No

Have you been advised to take antibiotics before dental care? Yes No

MEDICAL ALERTS

HAVE YOU EVER HAD THE FOLLOWING: YES NO

Allergic or adverse reaction to:

- aspirin, ibuprofen, acetaminophen _____ YES NO
- penicillin or other antibiotics _____ YES NO
- codeine or other narcotics _____ YES NO
- local anesthetic _____ YES NO
- fluoride _____ YES NO
- metals _____ YES NO
- latex or other dental materials _____ YES NO
- any other medications _____ YES NO

Heart problems

- heart murmur _____ YES NO
- rheumatic fever _____ YES NO
- heart surgery _____ YES NO
- heart valve _____ YES NO

High blood pressure _____ YES NO

Low blood pressure _____ YES NO

Alcohol or drug abuse _____ YES NO

Anemia or other blood disorder _____ YES NO

Arthritis _____ YES NO

Asthma _____ YES NO

Breathing/Sleep problems _____ YES NO

Cancer/Tumor _____ YES NO

chemotherapy _____ YES NO

radiation therapy _____ YES NO

Anxiety / Panic Attacks _____ YES NO

Diabetes (type _____) _____ YES NO

Digestive disorders (i.e. gastric reflux) _____ YES NO

- Eating Disorder _____ YES NO
- Emphysema _____ YES NO
- Epilepsy, convulsions (seizures) _____ YES NO
- Frequent headaches _____ YES NO
- Glaucoma _____ YES NO
- Head or neck injuries _____ YES NO
- Hearing aid _____ YES NO
- Hepatitis (type _____) _____ YES NO
- High cholesterol _____ YES NO
- Hives, skin rash, hay fever _____ YES NO
- HIV/AIDS _____ YES NO
- Joint replacement _____ YES NO
- Kidney disease _____ YES NO
- Liver disease _____ YES NO
- Lumps or swelling in the mouth _____ YES NO
- Mental health problems _____ YES NO
- Neurological problems _____ YES NO
- Osteoporosis/osteopenia _____ YES NO
- Smoke or tobacco use _____ YES NO
- Stroke _____ YES NO
- Thyroid (type _____) _____ YES NO
- Viral infections (i.e. cold sores) _____ YES NO
- Ulcers _____ YES NO
- Female
 - Taking birth control pills _____ YES NO
 - Pregnant _____ YES NO

List any medications, supplements, and or vitamins you are currently taking:

Drug	Reason
_____	_____
_____	_____
_____	_____
_____	_____

Drug	Reason
_____	_____
_____	_____
_____	_____
_____	_____

Comments: _____

Patient Signature _____ Dr. Initials _____ Date _____