Health History

Patient Name ____________________________________

Birth date _____________ Phone #___________________

Are you under the care of a Physician? ☐ yes ☐ no

Why? ____

____

What medications or pills are you currently taking?

____

____

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What Herbs or diet supplements do you take regularly?

____

Are you taking medication for preventing osteoporosis?

Please list __________________________________

Are you allergic to any medications or substances?

☐ Aspirin ☐ Codeine ☐ Penicillin ☐ Latex ☐ Sulfa

☐ Jewelry/Metals ☐ Other ______________________

____

Have you ever been instructed to pre-medicate with antibiotics before receiving dental care? ☐ yes ☐ no

For Women: Are you pregnant? ☐ yes ☐ no

Have you experienced the following?

	Yes	No		Yes	No
Rheumatic fever	☐	☐	Cancer/ Tumors	☐	☐
Heart murmur	☐	☐	Radiation Tx	☐	☐
Mitral valve prolapse	☐	☐	Chemotherapy	☐	☐
Any heart problem	☐	☐	Asthma	☐	☐
Heart Surgery	☐	☐	Epilepsy / seizures	☐	☐
Pacemaker	☐	☐	Kidney Disease	☐	☐
Joint Replacement	☐	☐	AIDS/ HIV	☐	☐
High Blood Pressure	☐	☐	Hemophilia	☐	☐
Diabetes	☐	☐	Hepatitis	☐	☐
Fainting/ Dizziness	☐	☐	Liver Disease	☐	☐
Sinus Problems	☐	☐	Venereal Disease	☐	☐
Do you Smoke?	☐	☐	Alcohol addiction	☐	☐
Do you chew tobacco?	☐	☐	Drug addiction	☐	☐

Please list any medical condition not listed above.

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____

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Dental History

Reason for today's visit? ____

When was your last dental check-up? __________________ Last panoramic or full set of x-rays taken? ______________

How often do you brush your teeth? ___________________ How often do you floss your teeth? _____________________

Please check any dental problems that apply

- ☐ Toothache
- ☐ Broken or chipped teeth
- ☐ Bleeding gums
- ☐ Hot, cold, sweet sensitivity
- ☐ Difficulty chewing
- ☐ Loose teeth
- ☐ Sores in the mouth
- ☐ Swelling or lumps
- ☐ Jaw joint pain (TMJ)
- ☐ Snoring
- ☐ Bad Breath
- ☐ Denture problems
- ☐ Difficult to numb
- ☐ Excessive bleeding after extraction or surgery?

Other concerns ____

If you could improve your smile, what might you change?

- ☐ Whiten teeth
- ☐ Repair chipped teeth
- ☐ Straighten uneven teeth
- ☐ Replace old fillings or crowns
- ☐ Close spaces
- ☐ Replace missing teeth

Other concerns ____

I understand that the information I have given is correct. I authorize release of this information for medical consultation and referral, as well as insurance submission. I also understand that it is my responsibility to inform this office of any changes of my medical status.

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(Signed) (Date)