**HEALTH HISTORY FORM**

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| Patient Last Name:Click here to enter text. | Patient First Name: Click here to enter text. | | Middle Initial: Click here to enter text. |
| Date: Click here to enter a date. | | | |
| Primary Reason for this dental appointment: | Examination | Consultation | Emergency |

**DENTAL HISTORY**

Describe any specific dental problems: Click here to enter text.  
Are there any changes you would like to make to your smile? Click here to enter text.  
Date of last dental examination: Click here to enter a date.  
Date of last full mouth x-rays: (16 small films or panorex): Click here to enter a date.

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| Do your gums ever bleed? | Yes | No |
| Do you have any loose teeth? | Yes | No |
| Do you have any loose fillings? | Yes | No |
| Do you think you have any cavities? | Yes | No |
| Does food catch between your teeth? | Yes | No |

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| Do you have noises (clicking, popping) in the jaw joint? | Yes | No |
| Do you have any discomfort in the jaw joint? | Yes | No |
| Do you clench or grind your teeth? | Yes | No |
| Do you use tobacco? | Yes | No |
| Are you aware of any growths or sores in your mouth? | Yes | No |

**MEDICAL HISTORY**

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| Are you under a physician’s care now? | Yes | No |
| Reason: Click here to enter text. | | |
| Physician’s Name: Click here to enter text. | | |
| Physician’s Phone Number: Click here to enter text. | | |

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| Have you ever been hospitalized or had a major operation in the past 5 years? | | | | | Yes | No |
| Have you ever had a serious injury to your head or neck? | | | | | Yes | No |
| If yes, please describe: Click here to enter text. | | | | | | |
| Are you taking any medications, pills, or drugs including non-prescription? | | | | | Yes | No |
| If yes, what medications? Click here to enter text. | | | | | | |
| Are you allergic to any medications or substances? | | | | | Yes | No |
| Aspirin | Penicillin | Codeine or other narcotics | Latex Rubber | Other: Click here to enter text. | | |

**WOMENS HEALTH**

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| Please check: | Pregnant | Nursing | Taking oral contraceptives | Discuss: Click here to enter text. |

**Please check any that apply:***(If yes to any of the starred (\*) conditions, please call prior to your appointment; premedication may be required.)*

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| Heart Trouble/Disease: | Yes  No | Leukemia | Yes  No | Excessive Thirst | Yes  No |
| Heart Murmur\* | Yes  No | Recent Blood Transfusion | Yes  No | Hypoglycemia | Yes  No |
| Irregular Heart Beat | Yes  No | Swelling of Limbs | Yes  No | Liver Disease | Yes  No |
| Angina/Chest Pain | Yes  No | Lung Disease | Yes  No | Hepatitis A (Infectious) | Yes  No |
| Heart Attack/Failure | Yes  No | Breathing Problem | Yes  No | Hepatitis B (Serum) | Yes  No |
| Congenital Heart Disorder | Yes  No | Shortness of Breath | Yes  No | Yellow Jaundice | Yes  No |
| Mitral Valve Prolapse\* | Yes  No | Frequent Cough | Yes  No | Kidney Problems | Yes  No |
| Scarlet Fever | Yes  No | Hay Fever | Yes  No | Renal Disease | Yes  No |
| Rheumatic Fever\* | Yes  No | Sinus Trouble | Yes  No | Thyroid Disease | Yes  No |
| Artificial Heart Valve\* | Yes  No | Asthma | Yes  No | Parathyroid Disease | Yes  No |
| Heart Pace Maker\* | Yes  No | Emphysema | Yes  No | Arthritis/Gout | Yes  No |
| Heart Surgery\* | Yes  No | Tuberculosis | Yes  No | Rheumatism | Yes  No |
| High Blood Pressure | Yes  No | Cancer | Yes  No | Pain in Jaw Joints | Yes  No |
| Low Blood Pressure | Yes  No | X-ray Treatments (Radiation) | Yes  No | Cortisone Medicine | Yes  No |
| Blood Disease | Yes  No | Chemotherapy | Yes  No | Artificial Joint\* | Yes  No |
| Bruise Easily | Yes  No | Stomach/Intestinal Disease | Yes  No | Venereal Disease | Yes  No |
| Anemia | Yes  No | Ulcers | Yes  No | AIDS | Yes  No |
| Excessive Bleeding | Yes  No | Recent Weight Loss | Yes  No | HIV Positive | Yes  No |
| Sickle Cell Anemia | Yes  No | Frequent Diarrhea | Yes  No | Genital Herpes | Yes  No |
| Hemophilia (Bleeding problem) | Yes  No | Diabetes | Yes  No | Drug Addition | Yes  No |
| Epilepsy or Seizures | Yes  No | Psychiatric Care | Yes  No | Cold Sores | Yes  No |
| Fainting or Dizziness | Yes  No | Alzheimer’s Disease | Yes  No | Fever Blisters | Yes  No |
| Glaucoma | Yes  No | Allergies (Medicines) | Yes  No | Herpes | Yes  No |
| Tumors or Growths | Yes  No | Allergies (Pollen/Dust) | Yes  No | Stroke | Yes  No |
| Nervousness | Yes  No | Hives or Rash | Yes  No | Convulsions | Yes  No |

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| Have you ever had any other serious illness not checked above? | Yes | No |
| If yes, please discuss: Click here to enter text. | | |
| Have your past experiences in a dental office always been positive? | Yes | No |
| Do you wish to talk to the dentist privately? | Yes | No |

*To the best of my knowledge, all of the preceding answers are correct. If I have any change in my health status or if my medications change, I shall inform the dentist and staff at the next appointment without fail.*

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| Patient Signature (Parent or Guardian): Click here to enter text. | Date: Click here to enter a date. |

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| Reviewed by Doctor: Click here to enter text. | Date: Click here to enter a date. |

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| History Review and significant findings: Click here to enter text. |