**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. |