BRONSON
FAMILY DENTISTRY

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# HEALTH HISTORY FORM

| Patient Last Name: | Patient First Name: | | Middle Initial: |
|---|---|---|---|
| Date: | | | |
| Primary Reason for this dental appointment: | ☐ Examination | ☐ Consultation | ☐ Emergency |

## DENTAL HISTORY

Describe any specific dental problems: _____

Are there any changes you would like to make to your smile? _____

Date of last dental examination: _____

Date of last full mouth x-rays: (16 small films or panorex): _____

| | | |
|---|---|---|
| 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 |

| | | |
|---|---|---|
| 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

| | | |
|---|---|---|
| Are you under a physician's care now? | ☐ Yes | ☐ No |
| Reason: | | |
| Physician's Name: | | |
| Physician's Phone Number: | | |

| | | |
|---|---|---|
| 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: | | |
| Are you taking any medications, pills, or drugs including non-prescription? | ☐ Yes | ☐ No |
| If yes, what medications? | | |
| Are you allergic to any medications or substances? | ☐ Yes | ☐ No |

| | | | | |
|---|---|---|---|---|
| ☐ Aspirin | ☐ Penicillin | ☐ Codeine or other narcotics | ☐ Latex Rubber | ☐ Other: |

**WOMENS HEALTH**

| Please check: | ☐ Pregnant | ☐ Nursing | ☐ Taking oral contraceptives | Discuss: |
|---|---|---|---|---|

**Please check any that apply:**

*(If yes to any of the starred (*) conditions, please call prior to your appointment; premedication may be required.)*

| | | | | | |
|---|---|---|---|---|---|
| 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 |

| | | |
|---|---|---|
| Have you ever had any other serious illness not checked above? | ☐ Yes | ☐ No |
| If yes, please discuss: | | |
| 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.*

| | |
|---|---|
| Patient Signature (Parent or Guardian): | Date: |

| | |
|---|---|
| Reviewed by Doctor: | Date: |

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|---|
| History Review and significant findings: |