HEALTH HISTORY

Name_____ Date _____ DOB _____ **Yes** **No**

Physician_____ Phone ( )_____

1. Are you currently under the care of a physician?..... ❑ ❑
2. Any changes in your general health within the past year?..... ❑ ❑

   If yes:_____
3. Have you had a serious illness, operation or hospitalized in past 5 years?..... ❑ ❑

   If yes:_____
4. Are you taking any prescription or over the counter medicines?..... ❑ ❑

   List Medicines: _____
5. Has a physician or previous dentist recommended that you take antibiotics prior to dental tx?..... ❑ ❑
6. Have you had a joint replacement?..... ❑ ❑

   If yes, when? _____ Doctor? _____
7. Are you allergic to any of the following:

   Penicillin ❑ Codeine ❑ Sulfa ❑ Aspirin ❑ Novocaine ❑ Latex ❑ No Allergy ❑

   Metals ❑ Local Anesthetic ❑ Gluten ❑

   Other Allergy?_____
8. Do you smoke or use smokeless tobacco?..... ❑ ❑

   Packs per day _____ How long have you used tobacco? _____

DO YOU CURRENTLY HAVE, OR HAVE YOU EVER HAD		YES	NO	IF YES, EXPLAIN
HEART				
9.	High Blood Pressure?			
10.	High cholesterol?			
11.	Chest pain / angina?			
12.	Heart attack? If yes, year			
13.	Cardiac stents?			
14.	Open heart surgery / bypass?			
15.	Artificial heart valves?			
16.	Irregular heartbeat / A-Fib?			
17.	Rheumatic fever / Heart murmur?			
18.	Congestive heart failure?			
19.	Pacemaker?			
LUNGS				
20.	Recent cold / bronchitis / pneumonia?			
21.	Chronic cough / asthma?			
22.	Emphysema / COPD?			
23.	Unable to lay flat?			
24.	Shortness of breath?			
25.	Tuberculosis?			
26.	Home oxygen?			
27.	Any other lung problems?			
NEUROMUSCULAR				
28.	Stroke? If yes, when			
29.	Seizures / epilepsy?			
30.	Migraines?			
31.	Anxiety / depression?			
32.	Fibromyalgia?			
33.	Other neurological problems?			

DO YOU CURRENTLY HAVE, OR HAVE YOU EVER HAD		YES	NO	IF YES, EXPLAIN
ANESTHESIA / AIRWAY				
34.	Malignant hyperthermia?			
35.	Nausea / vomiting?			
OTHER MEDICAL CONDITIONS				
36.	Sleep apnea / CPAP / Snoring?			
37.	Cancer / Tumor?			
38.	Radiation / Chemotherapy?			
39.	Arthritis?			
40.	Recurring infection? Type			
41.	Contacts / glasses?			
42.	Eye disease / glaucoma?			
43.	Bleeding disorders?			
44.	Chronic fatigue?			
45.	Persistant swollen glands in neck?			
46.	Ever had MRSA / shingles?			
47.	AIDS / HIV Positive?			
ENDOCRINE				
48..	Diabetes?			
49.	Thyroid disease?			
50.	Steroid use?			
51.	Hypoglycemia?			
GASTROINTESTINAL				
52.	Heartburn / reflux?			
53.	Ulcers / gastritis?			
54.	Chrohn's / colitis / IBS?			
KIDNEY / LIVER				
55.	Hepatitis / jaundice / cirrhosis?			
56.	Kidney disease / dialysis?			
SMOKING / ALCOHOL / OTHER				
60.	Recreational drug use?			
61.	Medical marijuana?			
62.	Drinks per week?			

DENTAL HISTORY

	Yes	No
63. Has the patient had any injuries to the face, mouth or teeth? Describe: _____	❑	❑
64. Do your gums bleed when you brush or floss?	❑	❑
65. Are your teeth sensitive to cold, hot, sweets, or pressure?	❑	❑
66. Does food or floss catch between your teeth?	❑	❑
67. Is your mouth dry?	❑	❑
68. Have you ever had perio (gum) treatments?	❑	❑
69. Have you ever had ortho (braces) treatments?	❑	❑
70. Have you had problems associated with previous dental treatments?	❑	❑
71. Is your home water fluoridated?	❑	❑
72. Are you currently experiencing dental pain or discomfort?	❑	❑
73. Do you have clicking, popping or discomfort in the jaw?	❑	❑
74. Do you clench or grind your teeth?	❑	❑
75. Do you have sores or ulcers in your mouth?	❑	❑
76. Do you wear dentures or partials?	❑	❑

NEW PATIENTS

Previous dentist _____

Date of last dental exam: _____ Date of last dental x-rays _____

WOMEN ONLY: (QUESTIONS 77-80)

	Yes	No
77. Is there a possibility of pregnancy.....	❑	❑
78. Expected delivery date? _____		
79. Are you nursing?	❑	❑
80. Are you taking any form of birth control?..	❑	❑

Note: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding other methods of birth control.*

CHANGES _____ Initial/Date _____ Initial/Date _____ Initial/Date _____ Initial/Date _____ Initial/Date