



PATIENT HEALTH HISTORY

Do you have a history of:

	Yes	No		Yes	No		Yes	No		Yes	No
A.I.D.S/HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems/Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Latex Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Head injuries	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impaired	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Malignancies	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Bone Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Valve, Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Neck & Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Type(s) _____			Nervous Problems/Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis Carrier	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or growths	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic Joints	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hip or Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	HPV	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>			

Medical Questions

List any medications you are taking including nonprescription drugs:

Do you have any disease/problem you think we should know about? YES No

Are you allergic to any medications? YES No If yes, please list below:

Have you had a transplant operation that has depressed your immune system?

YES No

Have you had an allergic reaction to Bananas?

YES No

Are you in good health?

YES No

Do you smoke or chew tobacco?

YES No

Date of last medical exam: _____

Have you had Heart Surgery?

YES No

Have you ever been hospitalized? YES No If yes, what was the problem

Are you now under the care of an MD?

YES No

Are you taking or have you ever taken bisphosphonates?
(Fosamax or Actonel for osteoporosis, chemotherapy, etc)

YES No

FOR WOMEN ONLY:

Are you taking birth control pills? YES No

Are you nursing/breastfeeding? YES No

Are you pregnant? YES No

Expected delivery date: _____

Is there a possibility of pregnancy? YES No

NOTE: Antibiotics (such as penicillin) may alter the effect of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.



PATIENT HEALTH HISTORY

Date: _____

Dental History Information

Dr. Signature: _____

Date of last dental visit? _____

Do you snore? YES No

Name of your previous dentist _____

Do you have problems with bad breath? YES No

Reason for today's visit? _____

Have you ever had an allergic reactions to a crown, metal filling or dental appliance? YES No

Have you ever had an oral cancer screening? YES No

Have you ever used an electric toothbrush? YES No

How often do you floss your teeth? _____

Are your teeth sensitive to hot, cold or pressure? YES No

Do your gums bleed when you brush? YES No

On a scale from 1 to 10, with 10 being the highest, how important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Have you or a family member ever been treated for periodontal disease? YES No

Have you ever had complications from an extraction? YES No

If you could change something about your smile what would it be:

Have you ever had a popping or clicking near your ear when you chew? YES No

- Whiter
- Straighter
- Close space
- replace black mercury filling with tooth colored restorations
- repair chipped teeth
- replace missing teeth
- less gums showing
- replace old crowns or caps that don't match

Are you prone to frequent headaches? YES No

Do you grind or clench your teeth? YES No

Do you have sores, blisters or swelling on your gums lips or cheeks? YES No

Date: _____

Have you ever had orthodontic treatment? YES No

I certify that I have read and understand the questions, above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his/her staff responsible for any errors that I have made in the completion of this form.

Adult/Guardian: I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or x-rays, as may be deemed necessary by the doctor.

Reviewed by: _____

Patient: _____ Date: _____

Parent/Guardian (if patient is a minor): _____ Date: _____