

HEALTH HISTORY

Name _____ Date _____

DENTAL HISTORY:

Please Check

Do you have a specific dental problem? Describe _____ Yes No
 Do you have dental examinations on a routine basis? Last visit _____ Yes No
 Do you think have active decay or gum Disease? _____ Yes No
 Do you brush and floss on a routine basis? Discuss _____ Yes No
 Do your gums ever bleed? Discuss _____ Yes No
 Do you like your smile? Why? _____ Yes No
 Does food catch between your teeth? Any loose teeth? _____ Yes No
 Do you want to keep your remaining teeth? _____ Yes No
 Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
 Have your past experiences in a dental office always been positive? _____ Yes No
 Any sores or growths in your mouth? Discuss _____ Yes No
 Name of previous dentist (optional) _____ Yes No
 Date of last full mouth x-rays (16 small films or panoramic) _____ Yes No

HEALTH HISTORY

Date of last health care exam: _____ What was this exam for? _____

Have you been hospitalized in the last 5 years? *(Please Check One)* No Yes

If yes, reason: _____

Are you currently receiving care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Heart Murmur (mitral valve prolapse)	No	Yes		Psychosis	No	Yes
Anemia	No	Yes		Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes		Previous Biopsies	No	Yes
Epilepsy	No	Yes		Slow-Healing Mouth Sores	No	Yes
Hepatitis, Any Form	No	Yes		Other Infections	No	Yes
Rheumatic Fever	No	Yes		Recurrent Illnesses	No	Yes
Asthma	No	Yes		Joint Replacement	No	Yes
HIV Positive or AIDS Related Complex	No	Yes		Glaucoma	No	Yes
Emphysema or other Respiratory Illnesses	No	Yes		Abnormal Bleeding from a cut	No	Yes
Abnormal Heart Condition	No	Yes		Liver Disease (including Jaundice)	No	Yes
Kidney Disease	No	Yes		Unintentional Weight Loss/Gain	No	Yes
Heart (Surgery, Disease, Attack)	No	Yes		Latex Sensitivity	No	Yes
Venereal Disease	No	Yes		H.I.V. Infection/AIDS	No	Yes

Are you required to Pre-Medicare before dental treatment? No Yes

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you taking birth control pills? No Yes

Abnormal Blood Pressure? **Please Check** No Yes
If yes, what is it usually: S /D

Are you allergic or have you had a reaction to:
a. Local anesthetics No Yes
b. Penicillin No Yes
c. Other antibiotics (if so, which one?) No Yes
d. Aspirin No Yes
e. Codeine, valium or other sedatives (if so, which one?) No Yes
f. Other _____

Are you a smoker? No Yes
If so, how much do you smoke per day? _____

Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes

Please list any medications you are currently taking:
1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Are you taking Tagamet (Cimetidine)? No Yes If yes, how often? _____

Do you take Antacids? No Yes If yes, how often? _____

Are you taking any herbal supplements/medicines? No Yes If yes, which ones? _____

Weight: _____

Diet: Restricted Diet _____
How many meals a day _____
Food Allergies _____
Sugar in your diet: None Slight Moderate High

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

Patient (Print Name) Patient Signature Date

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

Significant findings from questionnaire or oral interview:

Dental management considerations:

Doctor (Print Name) Doctor Signature Date