HEALTH HISTORY

Patient Name _____ **Date of Birth** _____

DENTAL INFORMATION

Reason for today's visit: **Exam** ☐ **Emergency** ☐ **Consultation** ☐
Are you in pain? **No** ☐ **Yes** ☐ **How long?** _____

Please indicate ☒ any of the following problems:

☐ Discomfort, clicking or popping in jaw	☐ Lost/Broken Filling(s)	☐ Stained Teeth
☐ Red, swollen or bleeding gums	☐ Teeth Grinding	☐ Locking Jaw
☐ Sensitive tooth, teeth or gums	☐ Ringing in Ears	☐ Bad Breath
☐ Blisters/Sores in or around mouth	☐ Broken/Chipped tooth	☐ Dental Phobias

☐ Other _____

Do you require anti-biotic pre-medication? ☐ Yes ☐ No

New Patients Only:
Last Dental Exam ___/___/___ **Last Dental X-rays** ___/___/___ **Times a day you brush** ____ **Times a week you floss** _____

NAME & ADDRESS OF PREVIOUS DENTIST:_____

MEDICAL HISTORY

Are you taking any of the following medications?

☐ Nerve pills ☐ Pain killers (including aspirin) ☐ Muscle relaxers ☐ Stimulants ☐ Blood thinners ☐ Tranquilizers

☐ Insulin ☐ Osteoporosis Drugs (Fosamax, Boniva, Actonel, Aredia) ☐ Other Medications _____

_____

Have you had any of the following diseases, medical conditions or procedures? (Please indicate ☒)

☐ Heart Attack/Stroke	☐ Thyroid Problems	☐ Cancer/Tumors	☐ Cosmetic Surgery
☐ Heart Surg/Pacemaker	☐ Kidney problems	☐ Shingles	☐ X-ray or Cobalt Treatment
☐ Heart Murmur	☐ Liver Problems	☐ Hepatitis	☐ Chemotherapy
☐ Rheumatic Fever	☐ Respiratory Problems	☐ HIV+/AIDS/ARC	☐ Asthma
☐ Mitral Valve Prolapse	☐ Sinus Problems	☐ Arthritis/Rheumatism	☐ Difficulty Breathing
☐ Artificial Valves	☐ Stomach Problems/Ulcers	☐ Diabetes/Hypoglycemia	☐ Heart Disease
☐ Psychiatric Problems	☐ Emphysema	☐ Leukemia	☐ Congenital Heart Defect
☐ Venereal Disease	☐ Fainting/Seizures/Epilepsy	☐ Anemia	☐ Chest Pains
☐ Alcohol/Drug Abuse	☐ Severe/Frequent Headaches	☐ High/Low Blood Pressure	☐ Scarlet Fever
☐ Tuberculosis TB	☐ Frequent Neck Pain	☐ Bleeding Problems	☐ Nervousness
☐ Jaw Problems TMJ/TMD	☐ Back Problems	☐ Glaucoma	

Have you had any bone/joint replacements? ☐ No ☐ Yes **Date of replacement** _____
Please list any other medical condition(s) you have or ever had _____
_____

Are you allergic to any of the following?

☐ Latex	☐ Penicillin/Amoxicillin	☐ Tetracycline
☐ Aspirin	☐ Dental Anesthetics	☐ Codeine

☐ Others _____

Do you use tobacco? ☐ No ☐ Yes/How Used? _____ **How Much?** _____ **How Long?** _____

Have you ever responded adversely to medical or dental treatment? _____**Have you been hospitalized within the last 5 years?**___
Are you currently under the care of a physician? ☐ No ☐ Yes
For what conditions? _____
Family Physician's Name _____ **Phone** _____
Specialist's Name _____ **Phone** _____
If patient is a child, what is his/her weight? _____
(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No
Are you taking birth control pills? ☐ Yes ☐ No

Is there anything else we should know about your medical history? _____
_____

- ***We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.***
- ***I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.***
- ***I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.***

Signature _____ **Date** _____/_____/_____ **6/03/2014**