Health History

Date:_______________

Name: ____________________________ **How do you prefer to be addressed?** ____________

Answers to the following questions are for our records only and are considered confidential.

1. Name and location of previous dentist: _______________________________________

2. Date of last dental exam _______________ Date of last dental X-rays ____________

3. Date of last physical exam _______________ Physician's Name:__________________

4. Have you or any other family members been seen previously at this office? ….(YES / NO)

5. Are you having any dental pain or discomfort at this time? ………………………(YES / NO)

6. Do you experience anxiety about having dental treatment? ……………………. (YES / NO)

7. Have you ever had a bad experience in a dental office? ………………………...(YES / NO)

8. Have you been a patient in the hospital during the past two years? ...……….. (YES / NO)

9. Have you been under the care of a medical doctor during the past two years? (YES / NO)

10. Have you ever needed treatment for excessive bleeding? ….………………… (YES / NO)

11. Have you had any type of allergic reaction (i.e. itching, rashes, swelling of hands, mouth, or eyes) to penicillin, aspirin, codeine, latex, metals, or medications? ………..(YES / NO)
If yes, please describe:____

12. Have you taken any medications or drugs in the past two years? If so, please list.
Note: If you are being treated for depression, osteoporosis, or hormone replacement therapy, please list the exact name of your prescription._______________________________

13. Women: Are you pregnant now? ***(Please inform us before X-rays are taken.)*** **….**(YES / NO)
Are you currently taking oral contraceptives? ……………………..………….. (YES / NO)

Circle any of the following health conditions you have had or have at present:

Heart Failure	Stroke	Arthritis	Fainting or
Heart Disease or Attack	Kidney Trouble	Rheumatism	Dizzy Spells
Angina Pectoris	Ulcers	Cortisone Medicine	Anxiety or
High blood Pressure	Emphysema	Glaucoma	Nervousness
Heart Murmur	Tuberculosis	AIDS or ARC	Psychiatric
Rheumatic Fever	Asthma	Hepatitis A (From Food)	Treatment
Congenital Heart	Hay Fever	Hepatitis B (From Serum)	Sickle Cell
Lesions	Sinus Trouble	Liver Disease	Disease
Scarlet Fever	Allergies or Hives	Yellow Jaundice	Bruise Easily
Artificial Heart Valve	Diabetes	Blood Transfusion	Eating Disorder
Heart Pacemaker	Thyroid Disease	(Date:)	Drug Addiction
Heart Surgery	Hemophilia	Radiation or Cobalt Treatment	(cocaine, meth.)
Artificial Joint	Cold Sores	Chemotherapy	
Anemia	Herpes	Epilepsy or Seizures	

Is there anything else about your health history you feel we should know?

DENTAL HEALTH QUESTIONS

14. Have you received instructions in oral hygiene? ………………………….…….. (YES / NO)

15. Are there any sores or growths in or around your mouth? ………………...… (YES / NO)

16. Does food tend to catch between your teeth? ……………………………...… (YES / NO)

17. Do you have trouble with bad breath? ………………………………………..… (YES / NO)

18. Do your gums bleed easily?……………………………………………......… (YES / NO)

19. Do you use tobacco products? Type: _________________ Quantity: ______________

20. Do you now or have you had piercings on your tongue or mouth? …………. (YES / NO)

21. Do you experience any limited movement or ability to open your jaw? ….… (YES / NO)

22. Do you feel your teeth are worn down or crack easily? ……………….…… (YES / NO)

23. Have you ever had trauma to the jaw or mouth? …………………………...… (YES / NO)

24. Have your teeth changed shape, size, or appearance over the years? …… (YES / NO)

25. Are you concerned you may have TMJ (temporo-mandibular joint) disorder? (YES / NO)
Are you currently receiving treatment for TMJ disorder? …..……………..…… (YES / NO)
If so, by whom?____

26. Circle any of the following conditions you are experiencing:
- Frequent headaches or migraines
- Facial pain or a tired facial muscles
- Recurring ear-aches or dizziness
- Clicking or popping sounds in the jaw
- Jaw locks open or closed
- Grind or clench teeth (day or night)

27. Have you had any teeth removed? ……………………………………………… (YES / NO)

28. Did you receive orthodontic treatment (braces)? ……………………………… (YES / NO)

29. Is there anything you do not like about your smile? …………………………… (YES / NO)

SIGNATURE: DATE:

This section to be completed on subsequent visits.

I have reviewed the information on my Health History, and have noted any changes.

(1) _____________ initials date (2) _____________ initials date (3) _____________ initials date (4) _____________ initials date

(5) _____________ initials date (6) _____________ initials date (7) _____________ initials date (8) _____________ initials date