HEALTH HISTORY

Name____ Date of Birth ___________Male____Female_____

Are you currently under a physicians care? ____Yes ____No. Details:_____________________________________

Physician's Name____Phone____________________________

Physician's Address____

Allergic to any medication? ____Yes ___No. **If yes please list & describe type of reaction.**

Medication __________________________________ Reaction____

Latex Allergy? ____ Yes _____ No. Please describe reaction____

Previous Surgeries? __Yes __No. Please list type of surgery and date performed.
____
____

List All Current Medications (Prescription, Over the Counter, Herbal Supplements)

Medication	**Dosage**	**Frequency**
1.________________________	________________________	________________________
2.________________________	________________________	________________________
3.________________________	________________________	________________________
4.________________________	________________________	________________________

Past & Current Medical Conditions (Please mark all that apply)

__Heart Disease
__Heart Failure/Attack
__Rheumatic Fever
__Heart Murmur
__Mitral Valve Prolapse
__Heart Surgery
__Congenital Heart Problem
__Artificial Heart Valve/Stent
__Pacemaker
__Implanted Defibrillator
__High Blood Pressure
__Stroke
__Diabetes ___A1C Level
__Family History of Diabetes
__Artificial Joints
__Organ Transplant
__High Cholesterol

__Bleeding Problem
__Hemophilia
__Blood Transfusion
__Anemia
__Leukemia
__Fainting/dizzy spells
__Nervousness
__Lung Disease
__Asthma
__Emphysema
__Sleep Apnea
__Tuberculosis
__Cancer
__Radiation Therapy
__Chemotherapy
__Kidney Disease

__Eating Disorder
__Acid Reflux/GERD
__Stomach Ulcer
__Liver Disease
__Hepatitis A, B, C
__HIV Positive
__Autoimmune Disease
__Thyroid Disease
__Glaucoma
__Sjorens Syndrome
__Fibromyalgia
__Arthritis
__Depression
__Psychiatric Disorder
__Epilepsy
__Cerebral Palsy
__Venereal Disease

If you have answered yes to any of the above please explain._____________________________________
____
____
____

Women:
__Pregnant (what trimester)? ____________
__Nursing
__Using an Oral Contraceptive

SIGNATURE____**DATE**___________________________

DENTAL HEALTH HISTORY

Your initial clinical exam combined with your dental and medical history is important for us to recommend the best overall treatment approach for you. Oral health is directly related to your overall health and specific medical conditions are related to your mouth. Please mention everything about your health.

What is the reason for your dental visit today? ____________________________________

How did you hear about our practice? ____

On a scale from 1-10 with 10 being the highest, how important our your teeth?___________

When was your last dental visit? ___________ Last dental cleaning? _________________

How frequently did you have your dental cleaning? _________________________________

Who was your previous dentist? __________________________Phone_______________

Were you told you have gum disease? ___________________ Were you treated?________

Have you ever had orthodontic treatment? _____ Do you wear orthodontic retainers? ______

Name of Orthodontist ______________________________Phone ___________________

Have you had oral surgery? _______ Wisdom teeth removed? _________When?_________

Have you had dental implants placed? ___________ How long ago?___________________

Do you or have you been told you grind/clench your teeth? __________________________

Do you have pain, popping or clicking in your jaws? ________________________________

Do you wear or have an occlusal appliance? ______________________________________

Do your wear dentures or partial dentures ? ____________ How long? ________________

Are any of your teeth sensitive to hot, cold or sweets? ______________________________

Is your mouth frequently dry? ______ Are you noticing any swelling or lumps?____________

Do you have any loose teeth or trouble chewing? __________________________________

Do you have any food that catches between your teeth?____________________________

Do you frequently get cold sores or oral blisters?___________________________________

Do you notice bad breathe or tastes?_________________ Do you gag easily?___________

Are you interested in whitening your teeth?_________ Enhancing your smile? ____________

Are you interested in cosmetic dental treatment or dental veneers? ___________________

Have you ever experienced a complication following dental treatment? ________________

Signature____Date_________________