PATIENT NAME:________________________________ TODAY'S DATE:_____________ DATE OF BIRTH: (M/D/Y)______ /______ /______

HEALTH HISTORY

Mark "Yes" or "No" if you have an allergy to any of the following:

ALLERGY TO:

Aspirin	Yes	No	**Latex**	Yes	No
Sleeping Pills	Yes	No	**Anesthetic**	Yes	No
Codeine	Yes	No	**Penicillin**	Yes	No
Iodine	Yes	No	**Sulpha**	Yes	No

Other __________________________

Mark "Yes" or "No" if you have or have had any of the following:

AIDS	Yes	No	**Hepatitis Type** _____	Yes	No
Anemia	Yes	No	**High Blood Pressure**	Yes	No
Arthritis	Yes	No	**HIV Positive**	Yes	No
Artificial Heart Valves	Yes	No	**Kidney Disease**	Yes	No
Artificial Joints	Yes	No	**Liver Disease**	Yes	No
Asthma	Yes	No	**Low Blood Pressure**	Yes	No
Back Problems	Yes	No	**Nerve Problems**	Yes	No
Blood Disease	Yes	No	**Radiation Treatment**	Yes	No
Chemotherapy	Yes	No	**Respiratory Disease**	Yes	No
Cancer or Tumor	Yes	No	**Rheumatic Fever**	Yes	No
Circulatory Problems	Yes	No	**Scarlet Fever**	Yes	No
Cough-persistent	Yes	No	**Sinus Trouble**	Yes	No
Cortisone Treatments	Yes	No	**Shortness of Breath**	Yes	No
Depression	Yes	No	**Skin Rash - Persistent**	Yes	No
Medication ____________________			**Stroke**	Yes	No
Diabetes	Yes	No	**Swollen Neck Glands**	Yes	No
Diarrhea – Constant	Yes	No	**Thyroid Problems**	Yes	No
Eating Disorder	Yes	No	**Tuberculosis**	Yes	No
Emphysema	Yes	No	**Ulcer**	Yes	No
Fainting	Yes	No	**Other**_________________________		
Glaucoma	Yes	□ No	**WOMEN:**		
Headaches	Yes	No	**Pregnant**	Yes	No
Heart Murmur	Yes	No	**Due Date**____________________		
Herpes	Yes	No	**Nursing**	Yes	No
Heart Problems	Yes	No	**Birth Control**	Yes	No

Does your family have a history of head, neck or oral cancer? Yes No

Physician Name_______________________ Phone Number_______________

Date and type of last visit____

Do you have instructions from a physician to take pre-medication for dental treatment? Yes No If Yes, Why?________________________________

Do you take blood thinners? Yes No

Have you been hospitalized or had a serious illness within the last 5 years? Yes No If Yes, Why?_________________________________

Current Medications____

Pharmacy Name____

DENTAL HISTORY

Reason for today's visit?_____________________________

Previous Dentist____________________________________

Date of last visit____________________________________

What was done then?_________________________________

Date of last x-rays____________________ ____________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Bleeding Gums	Yes	No
Sores in mouth	Yes	No
Orthodontic treatment	Yes	No
Dry mouth	Yes	No
Food collection between teeth	Yes	No
Bad Breath	Yes	No
Gums swollen or tender	Yes	No
Lip or cheek biting	Yes	No
Loose teeth or broken fillings	Yes	No
Mouth breathing	Yes	No
Mouth pain when brushing	Yes	No
Sensitivity to cold	Yes	No
Sensitivity to biting	Yes	No
Sensitivity to sweets	Yes	No

Have you ever experienced the following problems:

Clicking in jaw	Yes	No
Difficulty in chewing	Yes	No
Difficulty in opening or closing	Yes	No
Pain (joint, ear, face)	Yes	No
Vertigo (dizziness)	Yes	No

Do you smoke or use chewing tobacco? ________________

Are you interested in quitting smoking? ________________

Do you drink alcohol? ______________________________

How often do you floss? ____________________________

How often do you brush? ___________________________

If you could change anything with your smile what would you change?____

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DENTAL / HEALTH HISTORY