PATIENT NAME:_______________________________ TODAY'S DATE:_________________________

HEALTH HISTORY

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

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	**High Blood Pressure**	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	**HIV Positive**	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	**Kidney Disease**	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	**Liver Disease**	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	**Low Blood Pressure**	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	**Nerve Problems**	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	**Radiation Treatment**	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	**Respiratory Disease**	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	**Rheumatic Fever**	☐ Yes	☐ No
Cancer or Tumor	☐ Yes	☐ No	**Scarlet Fever**	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	**Sinus Trouble**	☐ Yes	☐ No
Cough-persistent	☐ Yes	☐ No	**Shortness of Breath**	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	**Skin Rash- Persistent**	☐ Yes	☐ No
Depression	☐ Yes	☐ No	**Sleep Apnea**	☐ Yes	☐ No
Diabetes Type_____	☐ Yes	☐ No	**Snoring**	☐ Yes	☐ No
Diarrhea-constant	☐ Yes	☐ No	**Stroke**	☐ Yes	☐ No
Eating Disorder	☐ Yes	☐ No	**Swollen Neck Glands**	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	**Thyroid Problems**	☐ Yes	☐ No
Fainting	☐ Yes	☐ No	**Tuberculosis**	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	**Ulcer**	☐ Yes	☐ No
HPV	☐ Yes	☐ No	**Other**__________________		
Headaches	☐ Yes	☐ No	**WOMEN:**		
Heart Murmur	☐ Yes	☐ No	**Pregnant**	☐ Yes	☐ No
Herpes	☐ Yes	☐ No	**Due date**________________		
Heart Problems	☐ Yes	☐ No	**Nursing**	☐ Yes	☐ No
Hepatitis Type ______	☐ Yes	☐ No	**Birth Control**	☐ Yes	☐ No

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

Have you had your tonsils and/or adenoids surgically removed? ☐ 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
Bad breath	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Food collection between teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain when brushing	☐ Yes	☐ No
Sores in mouth	☐ Yes	☐ No
Sensitivity to biting	☐ Yes	☐ No
Sensitivity to cold	☐ 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 (TMJ, ear, face)	☐ Yes	☐ No
Vertigo (dizziness)	☐ Yes	☐ No

Do you smoke or use chewing tobacco? ________________

Do you use marijuana or cannabis? ___ ________________

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?_________________________________
____
____

DENTAL / HEALTH HISTORY