HEALTH HISTORY

NAME: ______________________
BIRTH DATE:_________________

Reason for visit: ___________________
When was your last dental visit: ______
What texture brush do you use?
__soft ___medium ___hard
Do your gums bleed while brushing or flossing? yes / no
Are your teeth sensitive to hot/cold or sweet/ sour foods or liquids
Have you noticed any loosening of your teeth? yes / no
Does food tend to become caught between your teeth? yes / no
Do you have any sores or lumps in or near your mouth? yes / no

____
Physician's Name _______________________
Date of last visit with physician ____________
Have you had any serious illnesses, hospitalization or operations?_____If yes,describe ____________
____
____
Have you ever had a blood transfusion? yes / no.
If yes,give approximate dates ______________
____

Circle if you have or have had any of the following:

Anemia	Cough,persistant
Arthritis	Cough up blood
Artificial heart valve	Diabetes
Artificial joints	Epilepsy
Asthma	Unexplained Fainting
Back problems	Glaucoma
Blood disease	Headaches
Cancer	Respiratory disease
Chemical dependency	Heart Attack
Chemotherapy	Hemophilia
Circulatory problems	Hepatitis
Congestive heart failure	Angina

DATE:____________

Have you ever experienced any of the following problems in your jaw ?
clicking / pain / difficulty chewing
Have you had any head,neck or jaw injuries? yes / no
Do you clench or grind your teeth while awake or asleep? yes / no / don't know
Do you bite your lips or cheeks frequently? yes / no
Have you ever had:
a.Orthodontic treatment(braces)? yes / no
b.Oral surgery? yes / no
c.Gum treatment? yes / no
d.Worn a bite plane or other appliance? yes / no

____

WOMEN

Are you pregnant? yes / no
Are you nursing? yes / no
Are you taking birth control pills? yes / no

____

Low Blood Pressure	
High Blood Pressure	Sexually Transmitted Disease
HIV/AIDS	Shortness of breath
Jaw pain	Skin rash
Kidney disease	Stroke
Liver disease	Swelling of feet or ankles
Leukemia	Thyroid problems
Congenital heart defects	Tobacco habit (smoking, snuff,etc.)
Pacemaker	Tonsilitis
Bacterial endocarditis	Tuberculosis
Radiation treatment	Other? _____________
Scarlet fever	
Ulcer	

MEDICATIONS

LIST MEDICATIONS YOU ARE CURRENTLY TAKING:

____
____
____
____

PHARMACY NAME:

____

PHONE #

____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my(or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

ALLERGIES:

CIRCLE ANY ALLERGIES BELOW.

Aspirin
Barbiturates(sleeping pills)
Codeine
Local anesthetic
Penicillin
Sulfa
Latex
Other ____________________

If you are allergic, what happens when you take the drug? Please explain.

____
____

SIGNATURE OF PATIENT,PARENT OR GUARDIAN:

____

DATE:________________