HEALTH HISTORY

Patient name _____

1) What is the reason for your visit today? _____
2) When was your last dental visit? _____
3) Do you have any dental problems now, please describe?

_____

Have you ever had an unfavorable reaction to dental treatment? _____ yes no
Have you ever had an unpleasant dental experience? _____ yes no
Do you have sensitive teeth? _____ yes no
Do your gums bleed? _____ yes no
Do you clench or grind your teeth while awake or asleep? _____ yes no
Have you ever had any injuries to your face or jaw? _____ yes no

Are you in good health? ---------- yes no
Are you under the care of a medical doctor? ---------- yes no
Are you taking any medications? Please list _____ yes no

_____

Indicate which of the following you have had or have at present:

Heart Trouble ---------- yes no
Chest pain ---------- yes no
Heart Murmur ---------- yes no
High Blood Pressure ---------- yes no
Mitral valve prolapse ---------- yes no
Artificial heart valve ---------- yes no
Heart pacemaker---------- yes no
Arthritis/rheumatism ---------- yes no
Stroke ---------- yes no
Artificial joints ---------- yes no
Kidney Trouble ---------- yes no
Ulcers ---------- yes no
Diabetes ---------- yes no
Thyroid Problems ---------- yes no
Tuberculosis ---------- yes no
Asthma ---------- yes no

Latex sensitivity---------- yes no
Allergies or hives ---------- yes no
Radiation therapy---------- yes no
Chemotherapy---------- yes no
Tumors/ cancer---------- yes no
Hepatitis---------- yes no
HIV positive---------- yes no
Osteoporosis---------- yes no
Liver disease---------- yes no
Hemophilia/ blood disorder------ yes no
Neurological disorders---------- yes no
Epilepsy/ seizures---------- yes no
Psychological treatment---------- yes no
Sinus trouble ---------- yes no
Emphysema---------- yes no
Cold Sores/blisters---------- yes no

Do you have or have you had any disease, condition, or problem not listed? _____

Are you aware of having an allergic reaction to any medication or substance? _____

Women: Are you pregnant? _____ Nursing?_____ Taking birth control pills? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/ Guardian Signature _____ Date _____

Doctor Signature _____ Date _____