

# Health History

## Dental History

Reason for today's visit \_\_\_\_\_

Former Dentist \_\_\_\_\_

Address \_\_\_\_\_

Date of last dental care \_\_\_\_\_ Date of last dental x-rays \_\_\_\_\_

**Check (✓) if you have had any problems with any of the following:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad Breath                    | <input type="checkbox"/> Grinding teeth                 | <input type="checkbox"/> Sensitivity to hot             |
| <input type="checkbox"/> Bleeding Gums                 | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets          |
| <input type="checkbox"/> Clicking or popping jaw       | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity when biting        |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold            | <input type="checkbox"/> Sores or growths in your mouth |
| <input type="checkbox"/> Chewing gum habit             | <input type="checkbox"/> Fingernail biting habit        |   |

How often do you floss? \_\_\_\_\_ How often do you brush \_\_\_\_\_

## Medical History

Physician's name \_\_\_\_\_ Date of your last visit \_\_\_\_\_

Have you ever had any serious illness or operations?  Yes  No If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No If yes, give approximate dates \_\_\_\_\_

(Women) Are you pregnant?  Yes  No Nursing?  Yes  No Taking birth control pills?  Yes  No

**Check (✓) if you have had any problems with any of the following:**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Aids                  | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Anemia                | <input type="checkbox"/> Cough, Persistent    | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough up Blood       | <input type="checkbox"/> HIV Positive          | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Artificial Joints     | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Back Problems         | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Blood Disease         | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Nervous Problems      | <input type="checkbox"/> Tobacco Problems           |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Pace Maker            | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Chemical Dependency   | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Ulcer                      |
| <input type="checkbox"/> Circulatory Problems  | <input type="checkbox"/> Describe _____       | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Chemotherapy          | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Respiratory disease   | <input type="checkbox"/> Venereal Disease           |

MEDICATIONS	REASON	ALLERGIES	
List all medications you are currently taking: _____ _____ _____ _____	_____ _____ _____ _____	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local anesthetics
		<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Penicillin
		<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
		<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
		<input type="checkbox"/> Latex	_____

Pharmacy Name \_\_\_\_\_  
Phone \_\_\_\_\_

**\*\*\*Please be aware that we ask you to give us 48 hours notice if you need to cancel or reschedule your appointment. If you do not show up for your appointment, or cancel the same day there may be a \$75.00 charge. This policy allows us to make your appointment available for other patients waiting to be seen\*\*\***

Signature \_\_\_\_\_ Date \_\_\_\_\_

*Payment is due in full at the time of treatment unless prior arrangements have been made*