

HEALTH HISTORY

For your safety and to assist us in accurately diagnosing and treating you, please carefully review this form completely and fill out all areas which pertain to you. ALL INFORMATION IS KEPT CONFIDENTIAL

Dental History:

Previous Dentist:

City:

How long:

Date of last visit:

Date of last dental cleaning:

Date of last full mouth x-ray:

1. Why did you leave your last dentist?

2. What did you like most about any dentist, or a dental office you have been to?

3. What did you like least about any dentist, or dental office that you have been to?

4. Are you having any discomfort at this time? Yes No

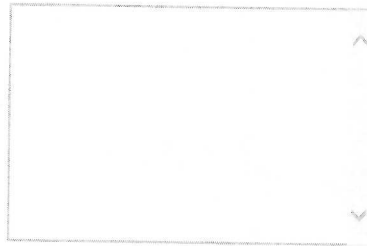
5. Have you ever had any serious trouble associated with previous dental treatment? Yes No

6. Does dental treatment make you nervous? Yes No

Yes No

7. Have you ever been treated for periodontal disease (gum disease)?

8. Chief Complaint?



Check any of the following you have had or currently have:

- Mouth discomfort
- Mouth Odor or Bad Taste
- Periodontal Treatment
- Cold Sores or Fever Blisters
- Gum Abscesses
- Gums Bleed when Brushing
- Loose or Shifting Teeth
- Trouble Chewing/Speaking
- Bruise Easily
- Grind or Clench your teeth
- Sensitive Teeth (Hot, Cold, Sweets)
- Awake with Sore Jaws
- Pain, Clicking, Popping in Jaw Joints
- Bad Dental Experience
- Fear of Dental Treatment
- Orthodontic Treatment
- Complications with or following previous dental or Oral Surgical treatment

If you could change one thing about your smile, what would that be?

Do you want to keep your teeth?

Medical Health History:

1. Describe your present health:

Height:

Weight:

2. List your current Physician(s) and their specialty:

3. List all illnesses or surgeries you have been hospitalized for in the past two years:

4. List all medications you are now taking (include over the counter):

List all medications you are allergic to:

Yes No

5. Are you taking blood thinners including aspirin?

6. Have you been under a medical doctor's care during the past two years? Yes No

7. Have you ever had excessive bleeding that required special treatment? Yes No

8. Do you smoke/vape? Yes No

How much?

How long?

Do you use smokeless tobacco? Yes No

9. Do you consume alcoholic drinks? Yes No

How many drinks per day?

per week?

Indicate which of the following you have had or presently have, check yes or no:

A Nervous Person Yes No

AIDS Yes No

Allergies or Hives Yes No

Anemia Yes No

Angina Yes No

Anxiety Disorder Yes No

*Artificial Joint (Knee, Hip) Yes No

* Arthritis Rheumatism Yes No

* Artificial Heart Valve Yes No

Asthma Yes No

Blood Transfusions Yes No

Birth Control Pills Yes No

Colitis Yes No

Cancers or Tumors Yes No

Chemotherapy Yes No

- Cosmetic Surgery Yes No
- Drug Abuse Yes No
- Diabetes Yes No
- Eating Disorder Yes No
- Emphysema Yes No
- Epilepsy or Seizures Yes No
- Fainting or Dizzy Spells Yes No
- Frequent Headaches Yes No
- Frequent Thirst/Urination Yes No
- Glaucoma Yes No
- Heart Disease or Attack Yes No
- Heart Murmur Yes No
- Heart Pacemakers Yes No
- Heart Surgery Yes No
- Heart Trouble Yes No
- Hemophilia Yes No
- Hepatitis Yes No
- High Blood Pressure Yes No
- HIV Positive Yes No
- If female, are you pregnant? Yes No
- Kidney or Bladder Trouble Yes No
- Low Blood Pressure Yes No
- Liver Disease Yes No
- Mitral Valve Prolapse Yes No
- Panic Attacks Yes No
- Persistent Cough Yes No
- Psychiatric Care Yes No
- Pneumocystis Yes No
- Radiation Treatment Yes No
- Shingles Yes No
- Shortness of Breath Yes No

Sinus Trouble Yes No

Stroke Yes No

Thyroid Disease Yes No

Tuberculosis Yes No

Ulcers Yes No

Weight Loss/Gain Yes No

Yellow Jaundice Yes No

*** If yes to any of starred conditions please call prior to appointment.**

Do you have any medical conditions or diseases we should know about? Yes No

Explain:

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Doctor Notes:

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To the best of my knowledge, all the preceding answers are true and correct. If I have any changes in my health or medicines, I will inform the Doctor on or before my next appointment, without fail.

Patient's Signature:

This form must be signed at the office.

Date:

Doctor's Signature:

This form must be signed at the office.

Date: