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:

Doctor Notes:

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: