HEALTH HISTORY

Patient Name _____ Date_____
Patient's Date of Birth _____

Dental History

HOW LONG SINCE you have seen a Dentist?
Last COMPLETE Dental Exam, Date:
Last FULL MOUTH X-RAYS, Date:
Is your present dental health POOR?
Do you wear DENTURES? (Partials or Full)
Are you UNHAPPY with your dentures?
Would you like to know more about PERMANENT REPLACEMENTS?
Are you APPREHENSIVE about dental treatment?
Have you ever had any PERIDONTAL (GUM) treatments? When:
Do your gums BLEED, or feel TENDER or IRRITATED?
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)
Are you UNHAPPY with the APPEARANCE of your teeth?
Are you aware of GRINDING or CLENCHING your teeth?
Do you have HEADACHES, EARACHES, or NECK PAINS?
Have you worn BRACES on your teeth? (ORTHODONTICS)
Do you have DISCOLORED teeth? Does it bother you?
Would you like your smile to LOOK BETTER or DIFFERENT?
Do you REGULARLY use DENTAL FLOSS?
Does food catch between your tooth?
Do you want to keep your remaining teeth?

Name of Previous Dentist: Phone #:

City: State:

Are you currently having **Dental Problems** now? If so, what?

Medical History

Do You have any **current health problems**?_____
Are you currently under a physician's care? If so, for what?_____
Are you **pregnant**?_____
Do you **smoke** cigarettes/cigars, pipe or chewing tobacco? (circle) _____
List all **medications** you are currently taking. Use back if necessary_____
_____
Name of Primary Care Physician_____Phone #_____

City:_____State_____

Are you allergic to or have you reacted adversely to any of the following? (circle)
Aspirin Local Anesthetic Erythromycin Nitrous Oxide Codeine Penicillin

Are you aware of being **allergic** to any other medications or substances? _____
If you, please list:_____
Is there any other Medical or Dental Information that you feel I should know?_____
_____

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

Heart Disease or Attack	A.I.D.S/A.R.C./HIV Pos.	Alcoholism	Cosmetic Surgery	Pain in Jaw Joints
Angina Pectoris	Hepatitis A B C	Heart Surgery	Chemotherapy (Cancer, Leukemia)	Sinus Trouble
High Blood Pressure	Liver Disease	Artificial Joints (Hip, Knee)	Venereal Disease	Allergies or Hives
Heart Murmur	Blood Transfusion	Anemia	(Syphilis, Gonorrhea, etc.)	Diabetes
Rheumatic Fever	Drug Addiction	Stroke	Bruise Easily	Thyroid Disease
Congenital Heart Lesions	Hemophilia (Bleeding Problems)	Kidney Troubles	Emphysema	Radiation Treatment
Mitral Valve Prolapse	Fever Blisters	Ulcers	Tuberculosis (TB)	Arthritis
Artificial Heart Valve	Epilepsy or Seizures	Psychiatric Treatment	Asthma	Cortisone Medicine
Heart Pacemaker	Nervousness	Glaucoma	Hay Fever	