HEALTH HISTORY

DENTAL INFORMATION

What is the reason for your dental visit today? _____

Do your gums bleed when you brush/floss? Y N
Are your teeth sensitive? Y N
Does food or floss catch between teeth? Y N
Is your mouth dry? Y N
Have you had periodontal(gum) treatments? Y N
Have you ever had orthodontic treatment? Y N
Do you have any clicking, popping or discomfort in the jaw? Y N
Do you grind your teeth? Y N
Do you have sores or ulcers in your mouth? Y N
Do you wear dentures or partials? Y N
Have you ever had a serious injury to your head or mouth? Y N
Are you currently experiencing dental pain or discomfort? Y N

Have you had any problems associated with previous dental treatment? _____

Date of last dental exam:_____ Date of last dental x-rays:_____

How do you feel about your smile?_____

MEDICAL INFORMATION

Are you in good health? Y N
Has there been any change in your general health within the past year? Y N
If yes, what condition is being treated?_____
_____

Have you had a serious illness, operation or been hospitalized in the past 5 years? Y N
If yes, what was the reason?_____
_____

Are you currently taking any prescription drugs? Y N If yes, please list them:
_____

Are you taking, or have you taken any diet drugs such as Phen-fen or Redux? Y N
Are you taking Fosamax or Actonel for Osteoporosis or Paget's disease? Y N
Do you use tobacco? Y N
Do you use alcohol or controlled substances? Y N
Have you had an orthopedic total joint replacement? Y N
If yes, what was the date? _____

WOMEN ONLY: Are you:
Pregnant? Y N Nursing? Y N Taking birth control or hormonal replacement? Y N

ALLERGIES – Are you allergic to or have you had a reaction to:

Local anesthetics Y N Aspirin Y N Penicillin Y N Barbituates Y N
Sulfa Drugs Y N Metals Y N Latex Y N Iodine Y N
Other:_____

Do you currently or have you had any of the following diseases or problems:

Heart murmur……Y N	Anemia……Y N	Chest pains……Y N	Neurological disorders……Y N
Mitral valve prolapse……Y N	Blood Transfusion……Y N	Chronic pain……Y N	If yes, specify:_____
Artificial heart valves……Y N	If yes, date:_____	Diabetes Type I/II……Y N	Mental health disorder……Y N
Rheumatic fever……Y N	Hemophilia……Y N	Eating disorder……Y N	If yes, specify:_____
Cardiovascular disease……Y N	Aids/HIV infection……Y N	Malnutrition……Y N	Recurrent infection……Y N
Angina……Y N	Arthritis……Y N	Gastrointestinal disease……Y N	Type of infection:_____
Arteriosclerosis……Y N	Autoimmune disease……Y N	Reflux/heartburn……Y N	Kidney problems……Y N
Congestive heart failure….Y N	Rheumatiod arthritis……Y N	Ulcers……Y N	Night sweats……Y N
Coronary Artery disease….Y N	Lupus……Y N	Thyroid problems……Y N	Osteoporosis……Y N
Damaged heart valves……Y N	Asthma……Y N	Stroke……Y N	Swollen Glands……Y N
Heart attack……Y N	Bronchitis……Y N	Glaucoma……Y N	Headaches/migraines……Y N
High blood pressure……Y N	Emphysema……Y N	Hepatitis……Y N	Severe/rapid weight loss…..Y N
Congenital heart defect….Y N	Sinus trouble……Y N	Jaundice……Y N	Sexually transmitted dis……Y N
Pacemaker……Y N	Hayfever……Y N	Liver disease……Y N	Excessive urination……Y N
Rheumatic heart disease…Y N	Tuberculosis……Y N	Epilepsy……Y N	
Abnormal bleeding……Y N	Cancer/chemo……Y N	Fainting spells……Y N	

Do you have any disease, condition or problem not listed above that we should know about? _____

_____ _____