PATIENT HEALTH HISTORY

NAME____________________ BIRTHDATE ___________ TODAY'S DATE___________ PURPOSE OF VISIT___________________

HOW LONG SINCE YOUR LAST VISIT? __________ PREVIOUS DENTISTS NAME_______________________ CITY____________

PHYSCIAN'S NAME___________________________________ PHONE #____________________ DATE OF LAST EXAM___________

HAVE YOU EVER HAD OR DO HAVE: ____ NONE OF THE BELOW

___ Rheumatic fever
___ Heart defect
___ Heart attack (Date________)
___ Active heart murmur
___ Pacemaker (Date_________)
___ Stroke (Date____________)
___ High Blood Pressure
___ Joint Replacement (pins, screws, plates, or implants (Date_______)
___ Scarlet Fever
___ Asthma
___ Diabetes
___ Hemophilic/Abnormal Bleeding

___ Thyroid problems
___ Sexually transmitted disease
___ HIV or AIDS infection
___ Mitral Valve Prolapse
___ Cancer (Type _____________)
___ Epilepsy/Seizures
___ Low Blood Pressure
___ Allergies, Hay fever, hives, skin rash
___ Nerve Conditions
___ Psychiatric Care
___ Weight Loss/Gain
___ Migraines/frequent headaches

___ Arthritis
___ Kidney trouble
___ Tuberculosis
___ Persistent cough
___ Leukemia
___ Anemia
___ Sinus trouble
___ Fainting spells
___ Stomach Ulcer
___ Hepatitis, jaundice, liver disease
___ Breathing lung problems
___ Lupus
___ Depression

ARE YOU PREGNANT, POSSIBLY PREGNANT, OR NURSING? ____

HAVE YOU EVER HAD A MAJOR SURGERY OR BEEN HOPITALIZED? ____
____

DO YOU HAVE ANY DISEASE OR CONDITION NOT LISTED ABOVE?____

DO YOU SMOKE, CHEW, USE SNUFF OR ANY OTHER FORM OF TOBACCO?_________ HOW MUCH? ___________________

DO YOU DRINK ALCOHOL? _______________________ DO YOU USE DRUGS?__________________________________

PATIENT ALLERGIES & MEDICATIONS

ALLERGIES (LIST ANY MEDICATIONS OR SUBSTANCES YOU ARE ALLERGIC TO OR HAD A REACTION TO)

_____ Penicillin _____ Sulfa drugs ______ Local Anesthetics_____ Latex or Metals _____ Codeine or Other Narcotics

_____ Iodine OTHER MEDICATIONS YOU ARE ALLERGIC TO____

ARE YOU OR HAVE YOU EVER TAKEN ACTONEL, AREDIA, BONIVA, FOSAMX, ZOMETA, OR ANY OTHER MEDICATION FOR OSTEOPEROSIS? __________________

LIST ANY MEDICATIONS, SUBSTANCES, HOMEPATHIC SUPPLEMENTS, HERBS, OR PILLS YOU ARE NOW TAKING_________

____

PATIENT DENTAL HISTORY

Do you see a dentist on a regular basis? ___________ Have you lost any teeth or have any been removed? ____________ Do you grind your teeth? _______________

Does your jaw pop or click? ______________ Do you have pain in your jaw or near your ears? _____________ Do your gums bleed or hurt? _____________________

Are you unhappy with the appearance of your teeth? ________ Have you ever had orthodontic treatment? _______ Have you ever had gum surgery? _______________

Have you had periodontal surgery? ____________ Is there anything about dentistry that you strongly dislike? ____

Have you had any problems or complications with previous dental treatment? ____

Are any of your teeth sensitive to: ___________ hot ___________ cold ___________ sweets __________ pressure

____
Date

____
PATIENT SIGNATURE (IF PATIENT IS A MINOR, PARENT OR LEGAL GUARDIAN SIGN)