

Patient Name: _____
(PRINT)

Sex: _____

Birthdate: _____

Social Security #: _____

HEALTH HISTORY: Health problems or medications that you may be taking could have an important interrelationship with the dentistry that you are receiving. Your dentist is legally obligated to ask you the following questions, thank you for answering them.

Physician: _____ Phone Number: _____

Are you in good health: _____ If no explain: _____

Are you currently under the care of a physician? (Please explain) _____

Have you been hospitalized in the last two years? _____

Are you taking any medications? (If yes, please list) _____

Do you NOW HAVE, or HAVE YOU EVER HAD any of the following? (Please check (X) box for EVERY question)

- | | YES | NO | | YES | NO | | YES | NO |
|-----------------------------------|--------------------------|--------------------------|--------------------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Heart Disease / Defect ----- | <input type="checkbox"/> | <input type="checkbox"/> | 12. Radiation Treatment ----- | <input type="checkbox"/> | <input type="checkbox"/> | 23. Breathing problems / Emphysema | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. High Blood Pressure ----- | <input type="checkbox"/> | <input type="checkbox"/> | 13. Liver Disease / Hepatitis ----- | <input type="checkbox"/> | <input type="checkbox"/> | 24. Unusual facial pain ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Infective Endocarditis ----- | <input type="checkbox"/> | <input type="checkbox"/> | 14. Kidney Disease ----- | <input type="checkbox"/> | <input type="checkbox"/> | 25. Head or neck injury ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Diabetes ----- | <input type="checkbox"/> | <input type="checkbox"/> | 15. Cold sores, Fever Blisters ----- | <input type="checkbox"/> | <input type="checkbox"/> | 26. Bisphosphonate therapy ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Stroke ----- | <input type="checkbox"/> | <input type="checkbox"/> | 16. Nervous at the Dentist ----- | <input type="checkbox"/> | <input type="checkbox"/> | 27. Antiplatelet therapy ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Epilepsy or Seizures ----- | <input type="checkbox"/> | <input type="checkbox"/> | 17. Asthma ----- | <input type="checkbox"/> | <input type="checkbox"/> | 28. Sensitivity to latex or balloons --- | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Fainting or Dizzy Spells ----- | <input type="checkbox"/> | <input type="checkbox"/> | 18. Recreational Drugs ----- | <input type="checkbox"/> | <input type="checkbox"/> | 29. Allergy to: | | |
| 8. Major Surgery ----- | <input type="checkbox"/> | <input type="checkbox"/> | 19. Smoke or chew tobacco ----- | <input type="checkbox"/> | <input type="checkbox"/> | (a) Penicillin ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Tumor History / Cancer ----- | <input type="checkbox"/> | <input type="checkbox"/> | 20. Tuberculosis ----- | <input type="checkbox"/> | <input type="checkbox"/> | (b) Other Antibiotics ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. VD / Herpes ----- | <input type="checkbox"/> | <input type="checkbox"/> | 21. Are you pregnant or trying ----- | <input type="checkbox"/> | <input type="checkbox"/> | (c) Aspirin ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. AIDS, ARC or HIV+ ----- | <input type="checkbox"/> | <input type="checkbox"/> | 22. Sinus trouble ----- | <input type="checkbox"/> | <input type="checkbox"/> | (d) Other ----- | <input type="checkbox"/> | <input type="checkbox"/> |

REMARKS: _____

DENTAL HISTORY:

Previous Dentist: _____ City: _____ State: _____

Do you have any present dental concerns? _____

When was your last full mouth x-ray taken? _____ Last cavity-detecting x-rays? _____

When was your last cleaning? _____ Were you pleased with the results? _____

Please check (✓) any of the following that you currently have or have had in the past:

- | | | |
|--|---|--|
| <input type="checkbox"/> Gum disease / gingivitis? | <input type="checkbox"/> Loosened adult teeth? | <input type="checkbox"/> Difficulty in opening mouth wide? |
| <input type="checkbox"/> Periodontal disease / gum surgery? | <input type="checkbox"/> Difficulty getting numb? | <input type="checkbox"/> Difficulty chewing? |
| <input type="checkbox"/> Instruction on oral hygiene? | <input type="checkbox"/> Popping, clicking, or pain in TMJ? | <input type="checkbox"/> Unfavorable experience in a previous dental office? |
| <input type="checkbox"/> History of clenching / grinding teeth? | <input type="checkbox"/> Sensitivity to hot, cold, or sweets? | |
| <input type="checkbox"/> Bad reaction to anesthetic / nitrous oxide? | <input type="checkbox"/> TMJ (jaw joint) problems/treatment? | |

Do you want to keep your remaining teeth? _____ Would you like to speak to the doctor privately? _____

Is there anything that concerns you about the appearance of your teeth or smile? _____

Are you pleased with the color and/or shape of your teeth? _____

What should we know about you to make your visits as comfortable as possible? _____

Whom may we thank for referring you to our office? _____

How would you like to be addressed in our office? (First / Last Name? Nickname?) _____

I hereby certify that the above is correct to the best of my knowledge. (It is the patient's responsibility to notify us if any of this information changes.)

Patient Signature and Date

Reviewing Doctor and Date