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|--------------------------------|------------|------------------|--------------------------|
| 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 will be 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 () box for EVERY question.

- | | YES | NO | | YES | NO | | YES | NO |
|--------------------------------|-----|-----|---------------------------------|-----|-----|---|-----|-----|
| 1. Heart Disease----- | ___ | ___ | 12. VD/Herpes----- | ___ | ___ | 24. Tuberculosis----- | ___ | ___ |
| 2. High Blood Pressure ---- | ___ | ___ | 13. AIDS, ARC, or HIV+ ---- | ___ | ___ | 25. Allergy to: | | |
| 3. Rheumatic Fever----- | ___ | ___ | 14. Radiation treatment----- | ___ | ___ | (a) Penicillin ----- | ___ | ___ |
| 4. Heart Murmur ----- | ___ | ___ | 15. Liver Disease /Hepatitis -- | ___ | ___ | (b) Other Antibiotics----- | ___ | ___ |
| 5. Diabetes----- | ___ | ___ | 16. Kidney disease----- | ___ | ___ | (c) Other ----- | ___ | ___ |
| 6. Stroke ----- | ___ | ___ | 17. Cold sores, Fever Blisters | ___ | ___ | 26. Are you pregnant or trying?----- | ___ | ___ |
| 7. Epilepsy or Seizures ----- | ___ | ___ | 18. Nervous at the Dentist----- | ___ | ___ | 27. Sinus trouble ----- | ___ | ___ |
| 8. Artificial Heart Valve ---- | ___ | ___ | 19. Asthma ----- | ___ | ___ | 28. Breathing problem/Emphysema---- | ___ | ___ |
| 9. Fainting or Dizzy Spells--- | ___ | ___ | 20. Thyroid disease ----- | ___ | ___ | 29. Artificial joints or prostheses ----- | ___ | ___ |
| 10. Major Surgery----- | ___ | ___ | 21. Recreational drugs----- | ___ | ___ | 30. Unusual Facial Pain----- | ___ | ___ |
| 11. Tumor History/Cancer---- | ___ | ___ | 22. Psychiatric treatment----- | ___ | ___ | 31. Head or neck injury ----- | ___ | ___ |
| | | | 23. Smoke or chew tobacco --- | ___ | ___ | 32. Sensitivity to latex or balloons----- | ___ | ___ |

REMARKS:

DENTAL HISTORY:

Previous Dentist: _____ City: _____ State: _____

Do you have any present dental complaints? _____

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:

- | | | |
|---|---|---|
| ___ Bleeding Gums? | ___ Loosened adult teeth? | ___ Gum Disease? Pyorrhea? Gingivitis? |
| ___ Periodontal Disease? | ___ Gum Surgery? | ___ Periodontal Surgery? |
| ___ Instruction in Oral Hygiene? | ___ Difficulty getting numb? | ___ TMJ (jaw joint) problems/treatment? |
| ___ History of clenching /grinding teeth? | ___ Popping, clicking, or pain in TMJ? | ___ Difficulty opening mouth wide? |
| ___ Unusual reaction to local anesthetic? | ___ Sensitivity to hot, cold, or sweets? | ___ Difficulty chewing on both sides? |
| ___ Unusual reaction to Nitrous Oxide? | ___ Unfavorable experience in a previous dental office? | |

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

If you could change anything about your smile or your teeth, what would it be? _____

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

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 if any of this information changes.)

| | |
|----------------------------|---------------------------|
| Patient signature and Date | Reviewing Doctor and Date |
|----------------------------|---------------------------|