

Health History

Name _____ Birthdate _____ Age _____

Dental History

General/Referring Dentist _____ Office Phone _____

Why are you now seeking dental treatment? _____

Have you ever had any serious trouble associated with previous dental treatment? _____

Does dental treatment make you nervous? No Slightly Moderately Extremely

Date of last dental visit _____

Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____

Do you or have or have you ever had any of the following?

	YES	NO		YES	NO
Bleeding, sore gums	<input type="checkbox"/>	<input type="checkbox"/>	Loose teeth	<input type="checkbox"/>	<input type="checkbox"/>
Unpleasant taste/bad breath	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to hot	<input type="checkbox"/>	<input type="checkbox"/>
Frequent blisters, lips/mouth	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to cold	<input type="checkbox"/>	<input type="checkbox"/>
Burning tongue/lips	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to sweets	<input type="checkbox"/>	<input type="checkbox"/>
Swelling/lumps in mouth	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to biting	<input type="checkbox"/>	<input type="checkbox"/>
Ortho treatments (braces)	<input type="checkbox"/>	<input type="checkbox"/>	Food impaction	<input type="checkbox"/>	<input type="checkbox"/>
Biting cheeks/lips	<input type="checkbox"/>	<input type="checkbox"/>	Clenching/grinding	<input type="checkbox"/>	<input type="checkbox"/>
Clicking/popping jaw	<input type="checkbox"/>	<input type="checkbox"/>	Shifting of teeth	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty opening or closing jaw	<input type="checkbox"/>	<input type="checkbox"/>	Change in bite	<input type="checkbox"/>	<input type="checkbox"/>

Medical History

Are you in good health now? Yes No Are you now under the care of a physician? Yes No

If so what is the condition being treated? _____

Have you ever been hospitalized or had a serious illness? Yes No

If yes, explain _____

Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously? Yes No

(Women) Are you pregnant? If so, give due date _____

Do you use tobacco in any form? Yes No If yes, how much _____

Do you use alcoholic beverages (more than 2 drinks per day)? _____

Are you ALLERGIC or have you ever experienced any reaction to the following?

	YES	NO		YES	NO
Local anesthetics (e.g. novocaine)	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin or codeine	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates/sedatives/sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin/other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	Other allergies _____		

Are you taking any of the following?

	YES	NO		YES	NO
Antibiotics/sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>	Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>
Blood thinners	<input type="checkbox"/>	<input type="checkbox"/>	Herbal supplements	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure medication	<input type="checkbox"/>	<input type="checkbox"/>	Insulin/other diabetes medications	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid medication	<input type="checkbox"/>	<input type="checkbox"/>	Recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone/steroids	<input type="checkbox"/>	<input type="checkbox"/>	Digitalis/other heart medications	<input type="checkbox"/>	<input type="checkbox"/>
Antihistamines/allergy/cold medication	<input type="checkbox"/>	<input type="checkbox"/>	Nitroglycerin	<input type="checkbox"/>	<input type="checkbox"/>
			Aspirin	<input type="checkbox"/>	<input type="checkbox"/>

Please complete reverse side

Please list all medication and dosage you are currently taking _____

Do you have or have you ever had any of the following?

GENERAL	YES	NO	HEART/BLOOD VESSELS	YES	NO
Tire easily, weakness	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Marked weight change	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain/discomfort	<input type="checkbox"/>	<input type="checkbox"/>
Persistent fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack/trouble	<input type="checkbox"/>	<input type="checkbox"/>
SKIN			Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Eruptions (rash) hives	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of ankles	<input type="checkbox"/>	<input type="checkbox"/>
Change in skin color	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
EYES			Congenital heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Visual change	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>
EARS			Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Loss of hearing	<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
NOSE			BONE/MUSCLES		
Frequent nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joints/limbs	<input type="checkbox"/>	<input type="checkbox"/>
THROAT			DIGESTIVE SYSTEM		
Soreness/hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
NERVOUS SYSTEM			Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Change in appetite	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Black, bloody or pale stools	<input type="checkbox"/>	<input type="checkbox"/>
Numbness/tingling	<input type="checkbox"/>	<input type="checkbox"/>	URNINARY		
Dizziness/fainting	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>	Increase in frequency of urination (night)	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY			Burning on urination	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Urethral discharge	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Bloody urine	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD		
Sputum production (phlegm)	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>
Cough up bloody sputum	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty breathing lying down	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE			OTHER		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Latex sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
Family history of diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid condition/goiter	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or growths	<input type="checkbox"/>	<input type="checkbox"/>
			Cancer	<input type="checkbox"/>	<input type="checkbox"/>
			HIV	<input type="checkbox"/>	<input type="checkbox"/>
			AIDS	<input type="checkbox"/>	<input type="checkbox"/>
			Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>

Signature _____ **Date** _____