HEALTH HISTORY

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name _____ Birth date _____ Age _____

Why are you now seeking dental treatment? _____

Please answer each question. Check yes or no. If in doubt, leave blank.

		Yes	No
1	Are you in good health now?	○	○
2	Are you now under the care of a physician?	○	○
	If so, what is the condition being treated?		
3	Have you ever been hospitalized or had a serious illness?	○	○
	If yes, explain		
4	Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously?	○	○
5	(Women) Are you pregnant? If yes, give due date	○	○
6	Do you use tobacco in any form? If yes, how much	○	○
7	Do you use alcoholic beverages (more than 2 drinks per day)?	○	○
8	Do you have or have you ever had any of the following?		

GENERAL

	Yes	No
Tire easily, weakness	○	○
Marked weight change	○	○
Night sweats	○	○
Persistent fever	○	○

SKIN

Eruption (rash) hives	○	○
Change in skin color	○	○

EYES

Visual change	○	○
Glaucoma	○	○

EARS

Loss of hearing	○	○
Ringing in ears	○	○

NOSE

Frequent nosebleeds	○	○
Sinus problems	○	○

THROAT

Soreness/hoarseness	○	○

NERVOUS SYSTEM

Stroke	○	○
Headaches	○	○
Convulsions/epilepsy	○	○
Numbness/tingling	○	○
Dizziness/fainting	○	○
Psychiatric treatment	○	○

RESPIRATORY

Tuberculosis	○	○
Emphysema	○	○
Asthma/hay fever	○	○
Persistent cough	○	○
Sputum production (phlegm)	○	○
Cough up bloody sputum	○	○
Difficulty breathing while lying down	○	○

ENDOCRINE

Diabetes	○	○
Family history of diabetes	○	○
Thyroid condition/goiter	○	○
Other	○	○

HEART/BLOOD VESSELS

	Yes	No
Rheumatic fever	○	○
Heart murmur	○	○
Chest pain/discomfort	○	○
Heart attack/trouble	○	○
Shortness of breath	○	○
Swelling of ankles	○	○
High blood pressure	○	○
Congenital heart disease	○	○
Mitral valve prolapse	○	○
Artificial heart valve	○	○
Pacemaker	○	○
Heart surgery	○	○
Other	○	○

BONE/MUSCLES

Arthritis/rheumatism	○	○
Artificial joints/limbs	○	○

DIGESTIVE SYSTEM

Hepatitis	○	○
Jaundice	○	○
Ulcers	○	○
Change in appetite	○	○
Black, bloody or pale stools	○	○

URINARY

Kidney disease	○	○
Increase in frequency of urination (night)	○	○
Burning on urination	○	○
Urethral discharge	○	○
Bloody urine	○	○
Venereal disease	○	○

BLOOD

Bruise easily	○	○
Anemia	○	○
Blood transfusion	○	○

OTHER

Radiation therapy	○	○
Chemotherapy	○	○
Tumors or growths	○	○
Cancer	○	○
HIV+	○	○
AIDS	○	○

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

	Yes	No		Yes	No
Local anesthetics (e.g., novocaine)	○	○	Aspirin or codeine	○	○
Barbiturates/sedatives/sleeping pills	○	○	Sulfa drugs	○	○
Penicillin/other antibiotics	○	○	Other allergies		

10 Are you taking any of the following?

	Yes	No		Yes	No
Antibiotics/sulfa drugs	○	○	Tranquilizers	○	○
Blood thinners	○	○	Insulin/other diabetes drugs	○	○
Blood pressure medication	○	○	Recreational drugs	○	○
Thyroid medicine	○	○	Digitalis/other heart medications	○	○
Cortisone/steroids	○	○	Nitroglycerin	○	○
Antihistamines/allergy drugs/cold remedies	○	○	Aspirin	○	○
			Other medication		

If yes to any of the above, list ***name*** of medication and ***dosage*** below:

1 _____
2 _____
3 _____
4 _____

11 Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do?
If so, explain _____

12 Physician's Name _____

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

14 Does dental treatment make you nervous? No ○ Slightly ○ Moderately ○ Extremely ○

15 Date of last dental visit _____

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

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

MOUTH

	Yes	No
Bleeding, sore gums	○	○
Unpleasant taste/bad breath	○	○
Burning tongue/lips	○	○
Frequent blisters, lips/mouth	○	○
Swelling/lumps in mouth	○	○
Other treatments (braces)	○	○
Biting cheeks/lips	○	○
Clicking/popping jaw	○	○
Difficulty opening or closing jaw	○	○

TEETH

	Yes	No
Loose teeth	○	○
Sensitive to hot	○	○
Sensitive to cold	○	○
Sensitive to sweets	○	○
Sensitive to biting	○	○
Food impaction	○	○
Clenching/grinding	○	○
Shifting teeth	○	○
Change in bite	○	○

ORAL HYGIENE

Do you use the following?	Yes	No
Brush	○	○
Dental floss	○	○
Fluoride rinse	○	○
Other		

How often do you brush _____

Brush is: Soft ○ Medium ○ Hard ○

To the best of my knowledge, all of the preceding answers are true and correct.
If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient, Parent, or Guardian _____ Date _____