

HEALTH HISTORY

Name _____

S.S.# _____

Address _____

Birth Date _____

_____ Zip _____

E-mail _____

Phone (H) _____ (W) _____ (Cell) _____

Who referred you to our practice? _____

What did they say about us that made you choose our practice? _____

What prompted you to seek dental treatment at this time? _____

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

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Are you in good health now? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you now under the care of a physician? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, what is the condition being treated? _____ | | |
| 3. Have you ever been hospitalized or had a serious illness? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, explain _____ | | |
| 4. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal new than previously? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. (Women) Are you pregnant? If so, give due date _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you use tobacco in any form? If yes, how much _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you use alcoholic beverages (more than 2 drinks per day)? | <input type="checkbox"/> | <input type="checkbox"/> |

8. Do you have or have you ever had any of the follow?

	YES	NO		YES	NO
GENERAL			HEART/BLOOD VESSELS		
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"/>
SKIN			Heart attack/trouble	<input type="checkbox"/>	<input type="checkbox"/>
Eruptions (rash) hives	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Change in skin color	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of ankles	<input type="checkbox"/>	<input type="checkbox"/>
EARS			High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Loss of hearing	<input type="checkbox"/>	<input type="checkbox"/>	Congenital heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>
NOSE			Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>
THROAT			Other	<input type="checkbox"/>	<input type="checkbox"/>
Soreness/hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	DIGESTIVE SYSTEM		
NERVOUS SYSTEM			Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Gastritis	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	URINARY		
Numbness/tingling	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/fainting	<input type="checkbox"/>	<input type="checkbox"/>	Increase in frequency of urination (night)	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>	Burning on urination	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY			Urethral discharge	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Bloody urine	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Veneral diseases	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/hay fever	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD		
Persistent cough	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>
Sputum production (phlegm)	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Cough up bloody spatum	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty breathing while lying down	<input type="checkbox"/>	<input type="checkbox"/>	OTHER		
ENDOCRINE			Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Family history of diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or growths	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid condition/goiter	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	HIV+	<input type="checkbox"/>	<input type="checkbox"/>
BONE/MUSCLES			AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints/limbs	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>			

(Please complete reverse side)

9. 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"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates/sedatives/sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin/other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain/discomfort	<input type="checkbox"/>	<input type="checkbox"/>

10. 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"/>	Insulin/other diabetes drugs	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure medications	<input type="checkbox"/>	<input type="checkbox"/>	Recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid medicine	<input type="checkbox"/>	<input type="checkbox"/>	Digitalis/other heart medications	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone/steroids	<input type="checkbox"/>	<input type="checkbox"/>	Nitroglycerin	<input type="checkbox"/>	<input type="checkbox"/>
Antihistamines/allergy drugs/cold remedies	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
			Other medications	<input type="checkbox"/>	<input type="checkbox"/>

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

1. _____ 3. _____
 2. _____ 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 _____ Phone _____

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

If so, when? _____

Please check any of the following problems that apply to you.

- Sensitivity (hot, cold, sweet)
- Tooth pain or discomfort when chewing
- Headaches, earaches, neck pain
- Jaw joint pain
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen, or irritated gums
- Loose, tipped, or shifting teeth
- Bad breath or bad taste in your mouth

If I could change my smile, I would:

- Make them brighter
- Make them straighter
- Close spaces
- Replace black metal filling with natural, tooth colored fillings
- Repair chipped teeth
- Replace missing teeth
- Replace old crowns that don't match
- Have a smile makeover

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

- | | YES | NO |
|------------------------------------|--------------------------|--------------------------|
| Dentures | <input type="checkbox"/> | <input type="checkbox"/> |
| Partial dentures | <input type="checkbox"/> | <input type="checkbox"/> |
| Braces | <input type="checkbox"/> | <input type="checkbox"/> |
| Periodontal (gum) treatments | <input type="checkbox"/> | <input type="checkbox"/> |

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you?
 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
 1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist? _____

If you could whiten your teeth for a cost anyone could afford, would you do it?

What is the most important thing to you about your future smile and dental health? _____

Do you smoke or use chewing tobacco?
 How much? _____ For how long? _____

What is the most important thing to you about your dental visit today?

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 _____ Date _____
 Parent, or Guardian _____