

# HEALTH HISTORY

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

## A Dental History

1. Reason for visit: \_\_\_\_\_
  2. When was your last dental visit? \_\_\_\_\_
  3. How often do you brush your teeth? \_\_\_\_\_
  4. What texture brush do you use?  Soft  Medium  Hard
- |  | YES                      | NO                       |   | YES                      | NO                       |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 5. Do your gums bleed while brushing?                                    | <input type="checkbox"/> | <input type="checkbox"/> | 11. Do you have frequent headaches?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do your gums bleed while flossing?                                    | <input type="checkbox"/> | <input type="checkbox"/> | 12. Do you clench or grind your teeth while awake or asleep?        | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you feel pain to any of your teeth when brushing or flossing them? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you ever had:  |                          |                          |
| 8. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids?   | <input type="checkbox"/> | <input type="checkbox"/> | a. Orthodontic treatment (braces)?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you noticed any loosening of your teeth?                         | <input type="checkbox"/> | <input type="checkbox"/> | b. Oral surgery?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever experienced any of the following problems in your jaw? |                          |                          | c. Gum treatment  | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Clicking?   | <input type="checkbox"/> | <input type="checkbox"/> | d. Your teeth ground or the bite adjusted?                          | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Pain (joint, ear, side of face)?                                      | <input type="checkbox"/> | <input type="checkbox"/> | e. Worn a bite plane or other appliance?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Difficulty in opening or closing                                      | <input type="checkbox"/> | <input type="checkbox"/> | 14. Are you satisfied with the appearance of your teeth?            | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Difficulty in chewing?  | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you ever had an upsetting experience in the dental office? | <input type="checkbox"/> | <input type="checkbox"/> |

## B Medical History

- |   | YES                      | NO                       |  | YES                      | NO                       |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Are you in good health?  | <input type="checkbox"/> | <input type="checkbox"/> | 7. Latex rubber?                                       |                          |                          |
| 2. Date of your last physical exam: _____   |                          |                          | 8. Other? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Physician's name _____<br>Address _____<br>Phone No. _____   |                          |                          | <b>Do you have or have you ever had the following:</b> |                          |                          |
| 4. Are you now under the care of a physician?   | <input type="checkbox"/> | <input type="checkbox"/> | 1. Rheumatic heart disease or rheumatic fever?         | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever been hospitalized for any surgical operation or serious illness? Please explain. _____               | <input type="checkbox"/> | <input type="checkbox"/> | 2. Scarlet fever?                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you taking any medicine(s) including non-prescription medicine? If yes, what medicine(s) are you taking? _____ | <input type="checkbox"/> | <input type="checkbox"/> | 3. Heart defect or heart murmur?                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you require antibiotic pre-medication?  | <input type="checkbox"/> | <input type="checkbox"/> | 4. Heart trouble, heart attack, or angina?             | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you had any abnormal bleeding?  | <input type="checkbox"/> | <input type="checkbox"/> | 5. Pacemaker?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you bruise easily?  | <input type="checkbox"/> | <input type="checkbox"/> | 6. Heart surgery?                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you use tobacco?   | <input type="checkbox"/> | <input type="checkbox"/> | 7. High/Low blood pressure? (circle one)               | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you use alcohol or other drugs?  | <input type="checkbox"/> | <input type="checkbox"/> | 9. Hepatitis, jaundice or liver disease?               | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Are you wearing contact lenses?   | <input type="checkbox"/> | <input type="checkbox"/> | 10. Stroke?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you have any disease, condition or problem not listed above that you think I should know about?                | <input type="checkbox"/> | <input type="checkbox"/> | 11. Sinus trouble?                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Women Only:</b>  |                          |                          | 12. Lung or breathing problems?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 1. Are you pregnant or think you may be pregnant?   | <input type="checkbox"/> | <input type="checkbox"/> | 13. Asthma or hay fever?                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you nursing?   | <input type="checkbox"/> | <input type="checkbox"/> | 14. Hives or skin rash?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you taking birth control pills   | <input type="checkbox"/> | <input type="checkbox"/> | 15. Fainting spells or seizures?                       | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Are you allergic to or have you had reactions to:</b>  |                          |                          | 16. Diabetes?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 1. Local anesthetics like novocaine?  | <input type="checkbox"/> | <input type="checkbox"/> | 17. AIDs or HIV infection                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Penicillin or other antibiotics?   | <input type="checkbox"/> | <input type="checkbox"/> | 18. Thyroid problems?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Sulfa drugs?   | <input type="checkbox"/> | <input type="checkbox"/> | 19. Allergies?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Barbiturates, sedatives or sleeping pills?   | <input type="checkbox"/> | <input type="checkbox"/> | 20. Arthritis or rheumatism?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Aspirin?   | <input type="checkbox"/> | <input type="checkbox"/> | 21. Joint replacement or implant?                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Iodine?  | <input type="checkbox"/> | <input type="checkbox"/> | 22. Stomach ulcer?                                     | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 23. Kidney trouble?                                    | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 24. Tuberculosis?                                      | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 25. Persistent cough?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 26. Cancer?  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 27. Sexually transmitted disease?                      | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 28. Epilepsy?  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 29. Anemia?  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 30. Leukemia   | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 31. Glaucoma?  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          |  |                          |                          |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT or GUARDIAN \_\_\_\_\_

DATE \_\_\_\_\_

