

HEALTH HISTORY
(Confidential)

DENTAL HISTORY

Reason for Today's Visit _____

Name of Dentist _____ Date of Last _____ Date of Last _____
Last Seen _____ Dental Care _____ Dental X-rays _____

Mark (X) if you have had problems with any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to cold |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sores or growths in mouth | <input type="checkbox"/> Sensitivity when biting |

How often do you brush? _____ How often do you floss? _____

What priority do you give your teeth (10 being the highest)? 1 2 3 4 5 6 7 8 9 10

Are you happy with the way your teeth and smile look? Yes No

Is there anything you would like different about your teeth or smile? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? Yes No If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate date _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Mark (X) if you have or have had any of the following:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swelling/Feet or Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | Describe _____ | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Venereal Disease |

MEDICATIONS

List all medications you are currently taking: _____

Pharmacy _____ Telephone _____

ALLERGIES

- | | |
|--|-------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Barbiturates (Sleeping Pills) | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> I have no allergies | |

SIGNATURE

To the best of my knowledge the above health history is true and correct.

Signature _____

Date _____