Patient Health History

Patient's Name: ____ **Date of Birth:** ______________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Any health problems that you have or medications that you take can have an important effect on the dentistry you will receive. Thank you for completing this form.

Reason for today's visit: ______________________________ Date of last dental care: ______________________________

Former Dentist: ______________________________ Date of last dental x-rays: ______________________________

How often do you brush? ______________________________ How often do you floss? ______________________________

Have you ever been diagnosed with or treated for gum disease? ¨ Yes ¨ No If yes, when: ____________________________________

Check if you have, or have you ever had, any of the following:

Bleeding Gums
Breath Malodor
Clicking or Popping of Jaw
Dry Mouth
Food Collection between Teeth
Grinding Teeth
Jaw Pain
Loose Teeth
Sensitivity when Biting
Sensitivity to Cold
Sensitivity to Heat
Sensitivity to Sweets
Broken Fillings
Sores or Growths in Your Mouth

If you had a magic wand, how would you change the appearance of your teeth? ____

	Yes	No	If Yes, explain:
Are you under a physician's care now?			
Have you ever been hospitalized or had a major operation?			
Have you ever had a serious head or neck injury?			
Are you taking any medications, pills or drugs?			
Do you take, or have you taken, Phen-Fen or Redux?			
Are you on a special diet?			
Do you use tobacco?			
Do you use controlled substances?			

Are you allergic to any of the following?	Yes	No
Aspirin		
Penicillin		
Codeine		
Acrylic		
Metal		
Latex		
Local Anesthetics		
Other allergies:		

Women - Are you:	Yes	No
Pregnant/Trying to get pregnant?		
Nursing?		
Taking oral contraceptives?		

Any family history of:	Yes	No
Heart disease?		
Diabetes?		
High blood pressure?		

Check if you have, or have you ever had, any of the following:

AIDS/HIV Positive
Alzheimer's Disease
Anaphylaxis
Anemia
Angina
Arthritis/Gout
Artificial Heart Valve
Artificial Joint
Asthma
Blood Disease
Blood Transfusion
Breathing Problem
Bruise Easily
Cancer
Chemotherapy
Back Problems
Chest Pains
Cold Sores/Fever Blisters
Congenital Heart Disorder
Convulsions
Cortisone Medicine
Diabetes
Drug Addiction
Easily Winded
Emphysema
Epilepsy or Seizures
Excessive Bleeding
Excessive Thirst
Fainting Spells/Dizziness
Frequent Cough
Frequent Diarrhea
Circulatory Problem
Frequent Headaches
Genital Herpes
Glaucoma
Hay Fever
Heart Attack/Failure
Heart Murmur
Heart Pace Maker
Heart Trouble/Disease
Hemophilia
Hepatitis A
Hepatitis B or C
Herpes
High Blood Pressure
Hives or Rash
Hypoglycemia
Fever, Prolonged
Irregular Heartbeat
Kidney Problems
Leukemia
Liver Disease
Low Blood Pressure
Lung Disease
Mitral Valve Prolapse
Pain in Jaw Joints
Parathyroid Disease
Psychiatric Care
Radiation Treatments
Recent Weight Loss
Renal Dialysis
Rheumatic Fever
Rheumatism
Lupus
Scarlet Fever
Shingles
Sickle Cell Disease
Sinus Trouble
Spina Bifida
Stomach/Intestinal Disease
Stroke
Swelling of Limbs
Thyroid Disease
Tonsillitis
Tuberculosis
Tumors or Growths
Ulcers
Venereal Disease
Yellow Jaundice
Night Sweats

Any serious illness not listed above? Yes No Explain: ____

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 the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

X____ ______________________________

Signature of Patient, Parent or Guardian Date