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?			
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?			
Are you on a special diet?			
Do you currently use or have you ever used 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
- ☐ Autism/Asperger's
- ☐ 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
- ☐ 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
- ☐ Osteoporosis
- ☐ 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
- ☐ Acid Reflux

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