HEALTH HISTORY

In order to better serve you and protect your health, we need to know your dental and medical history. Your history will be carefully reviewed and used to aid us in giving you the highest dental care.

Physicians Name:_____ Phone #:_____
Date of last physical examination:_____
Have you been hospitalized within the past two years? **Yes**_____ **No**_____
Have you been under the care of a physician in the past two years? **Yes**_____ **No**_____
Are you **allergic** to penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medications?__
_____
Is there anything which gives you a rash, itching, swelling of the hands, feet or eyes?_____
Have you ever had excessive bleeding requiring special treatment? **Yes**_____**No**_____

Circle (yes or no to the following)

YES NO 1. Are you having pain or discomfort at this time?_____
YES NO 2. Do you feel nervous about having dental treatment?_____
YES NO 3. Have you ever had a bad experience in the dental office?_____
YES NO 4. Is there anything that you dislike about your smile?_____
YES NO 5. Have you ever had any instructions in oral hygiene?_____
YES NO 6. Are there now any growths or sores in or around your mouth?_____
YES NO 7. Do you have trouble chewing?_____
YES NO 8. Does food catch between your teeth?_____
YES NO 9. Do you have pain in or near your ears?_____
YES NO 10. Do you habitually clench or grind your teeth during the day or night?_____
YES NO 11. Have you ever been told that you have gum problems?_____
YES NO 12. Is there anything related to your medical or dental history that you have not indicated above?
If yes, explain?_____
Please list all current medications:_____

Circle any of the following you have had or presently have:
*** Antibiotic premedication may be required prior to your appointment.**

Heart Failure
Heart Disease/Attack
Angina Pectoris
High Blood Pressure
***Mitral Valve Prolapse**
***Heart Murmur**
***Rheumatic Fever**
Congenital Heart Lesions
Heart Pace Maker _____
Heart Surgery_____
Cancer (Type:_____)
Anemia
Stroke
Epilepsy
***Artificial Hip, Knee or Joint**

Kidney Disorders
Ulcers
Use of Tobacco Products
Emphysema
Tuberculosis (TB)
Asthma
Sinus Problems
Hay Fever
Allergies or Hives
Diabetes
Radiation Treatment
Chemotherapy
Arthritis
Fainting or Dizzy Spells
Sickle Cell Disease

HIV Positive, ARC, AIDS
Alcoholism
Drug Addiction
Glaucoma
Cortisone Medicine
Hepatitis (Type:_____)
Liver Disease
Jaundice
Blood Transfusion
Bleeding Disorder
Bruise Easily
Cold Sores
Herpes
***Any type of implant**_____
***Any type of Transplant**_____

WOMEN:
Are you pregnant? **Yes/No** Are you nursing**? Yes/No** Are you taking birth control pills? **Yes/No**

Signature:_____ Date:_____
I have reviewed my medical history and the above information (including changes) is accurate.

Date:_____ Initials:_____ Date:_____ Initials:_____ Date:_____ Initials:_____
Date:_____ Initials:_____ Date:_____ Initials:_____ Date:_____ Initials:_____