

# Health History

First Name - Patient \*

Middle Name

Last Name - Patient \*

Patient Date of Birth



## Dental Information

- |   |   |
|---|---|
| <input type="checkbox"/> Do your gums bleed when you brush or floss?                          | <input type="checkbox"/> Are you currently experiencing dental pain or discomfort?        |
| <input type="checkbox"/> Are your teeth sensitive to cold, hot, sweets, or pressure?          | <input type="checkbox"/> Do you have earaches or neck pains                               |
| <input type="checkbox"/> Does food or floss catch between your teeth?                         | <input type="checkbox"/> Do you have any clicking, popping, or discomfort in your jaw?    |
| <input type="checkbox"/> Have you had any periodontal (gum) treatment?                        | <input type="checkbox"/> Do you grind your teeth?   |
| <input type="checkbox"/> Have you ever had orthodontic (braces) treatment?                    | <input type="checkbox"/> Do you have any sores or ulcers in your mouth?                   |
| <input type="checkbox"/> Have you had any problems associated with previous dental treatment? | <input type="checkbox"/> Have you ever had a serious injury to your head, neck, or mouth? |

Do you have cosmetic or function related concerns with your smile?

## Medical Information

### Allergies

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> Acetaminophen/Tylenol® | <input type="checkbox"/> Hay fever/seasonal       | <input type="checkbox"/> Morphine     |
| <input type="checkbox"/> Acrylic                | <input type="checkbox"/> Ibuprofen/Motrin®/Advil® | <input type="checkbox"/> Penicillin   |
| <input type="checkbox"/> Aspirin                | <input type="checkbox"/> Iodine                   | <input type="checkbox"/> Sulfa        |
| <input type="checkbox"/> Codeine                | <input type="checkbox"/> Latex                    | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Erythromycin           | <input type="checkbox"/> Local anesthetic         |                                       |
| <input type="checkbox"/> Fluoride               | <input type="checkbox"/> Metals                   |                                       |
| <input type="checkbox"/> Other                  |   |                                       |

Please elaborate on any reactions you have to the indicated allergies

**Conditions**

- Abnormal/excessive bleeding
- AIDS or HIV infection
- Alzheimer's/dementia
- Anemia
- Angina
- Anxiety
- Arteriosclerosis
- Arthritis
- Asthma
- Autoimmune disease
- Back problems
- Blood disease
- Blood transfusion
- Breathing problems/respiratory disease
- Bronchitis
- Cancer/chemotherapy/radiation treatment
- Cardiovascular disease
- Chest pain upon exertion
- Chronic pain
- Congestive heart failure
- Damaged heart valves
- Other
- Diabetes
- Eating disorder
- Emphysema
- Epilepsy
- Fainting spells or seizures
- Frequent headaches
- Gastrointestinal disease
- G.E. Reflux/persistent heartburn
- Glaucoma
- Gout
- Hearing difficulties
- Heart attack
- Heart murmur
- Heart rhythm disorder
- Hemophilia
- Hepatitis, jaundice or liver disease
- High blood pressure
- Kidney problems
- Low blood pressure
- Low pain tolerance
- Malnutrition
- Mitral valve prolapse
- Neurological disorders
- Night sweats
- Osteoporosis/Paget's disease
- Other congenital heart defects
- Pacemaker
- Persistent swollen glands in neck
- Psychiatric care
- Recurrent Infections
- Rheumatic fever
- Rheumatic heart disease
- Rheumatoid arthritis
- Severe headaches/migraines
- Severe or rapid weight loss
- Sexually transmitted infection (STI)
- Sinus trouble
- Stroke
- Systemic lupus erythematosus
- Thyroid problems
- TMJ Disorder
- Tuberculosis
- Tumors or growths
- Ulcers

Do you have any disease, condition or problem that is not listed that you think I should know about?

- Are you taking any prescriptions or over-the-counter medications? If yes, please list them below. If no, write 'N/A': \*
- Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?
- Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?
- Do you have sleep apnea?

- Have you ever reacted adversely to any medications or injections?
- Has there been any change to your general health within the past year?

- Do you use tobacco (smoking, snuff, chew, bidis, vaping)?
- Are you wearing a nicotine patch?

- Are you pregnant?
- Are you nursing?

- Are you taking birth control or hormone replacement?

Please list any surgical procedures you have undergone and when they occurred.

Have you ever taken FosaMax®, Boniva®, Actonel®, or other medications containing bisphosphonates?

Please read the above, and understand that the information provided in this form is accurate. A truthful health history will help ensure the best possible dental treatment. The information provided here will be used by the doctor and patient to inform any further discussion of the patient's health prior to or during an appointment. By signing below you also acknowledge that you will not hold the dentist, the dental practice or any other member of the practice staff responsible for any action or lack of action because of errors or omissions that may have been made during the completion of this form.

Print name

I agree that the information provided in this form is correct to the best of my knowledge.

Clear