

Health History

Name _____ Birthdate _____ Today's Date _____

A Dental History

- Reason for visit: _____
- When was your last dental visit? _____
- How often do you brush your teeth? _____
- What texture brush do you use? Soft Medium Hard
- Do your gums bleed while brushing?

	Yes	No		Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you had any head, neck, or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>
- Do your gums bleed when flossing?

	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
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- Do you feel pain to any of your teeth when brushing or flossing them?

	<input type="checkbox"/>	<input type="checkbox"/>	15. Do you clench or grind your teeth while awake or asleep?	<input type="checkbox"/>	<input type="checkbox"/>
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- Are your teeth sensitive to hot, cold, sweet or sour foods/liquids?

	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
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- Have you noticed any loosening of your teeth?

	<input type="checkbox"/>	<input type="checkbox"/>	17. Have you ever had:		
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 - Orthodontic treatment (braces)?
 - Oral surgery?
 - Gum treatment?
 - Your teeth ground or the bite adjusted?
 - Worn a bite plane or other appliance?
- Does food tend to become caught between your teeth?

	<input type="checkbox"/>	<input type="checkbox"/>	18. Are you satisfied with the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
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- Do you have any sores or lumps in or near your mouth?

	<input type="checkbox"/>	<input type="checkbox"/>	19. Have you ever had an upsetting experience in the dental office?	<input type="checkbox"/>	<input type="checkbox"/>
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- Have you ever experienced any of the following problems in your jaw?

a. Clicking?	<input type="checkbox"/>	<input type="checkbox"/>	20. Is there anything about having dental treatment that bothers you?	<input type="checkbox"/>	<input type="checkbox"/>
b. Pain (joint, ear, side of face)?	<input type="checkbox"/>	<input type="checkbox"/>			
c. Difficulty in opening or closing?	<input type="checkbox"/>	<input type="checkbox"/>			
d. Difficulty in chewing?	<input type="checkbox"/>	<input type="checkbox"/>			

B Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

- | | | | | | |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| | Yes | No | | Yes | No |
| 1. Are you in good health? | <input type="checkbox"/> | <input type="checkbox"/> | 8. Have you had any abnormal bleeding? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have there been any changes in your general health within the past year? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you bruise easily? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Date of your last physical exam: _____ | | | 10. Have you ever required a blood transfusion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Physician's name _____ | | | 11. Have you had a recent weight loss? | <input type="checkbox"/> | <input type="checkbox"/> |
| Address _____ | | | 12. Do you use tobacco? | <input type="checkbox"/> | <input type="checkbox"/> |
| Phone No. _____ | | | 13. Are you wearing contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you now under the care of a physician? | <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you have any disease, condition or problem not listed above that you think I should know about? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever been hospitalized for any surgical operation or serious illness? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Please explain: _____ | | | | | |
| 7. Are you taking any medicine (s) including non-prescription medicine? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| If yes, what medicine (s) are you taking? _____ | | | | | |

Women Only:

- Are you pregnant or think you may be pregnant?
- Are you nursing?
- Are you taking birth control pills?

(Over)

C Medical History Continued...

	Yes	No		Yes	No
Are you allergic to or have you had reactions to:			8. Low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
1. Local anesthetics like novocaine?	<input type="checkbox"/>	<input type="checkbox"/>	9. Hepatitis, jaundice or liver disease?	<input type="checkbox"/>	<input type="checkbox"/>
2. Penicillin or other antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>	10. Stroke?	<input type="checkbox"/>	<input type="checkbox"/>
3. Sulfa drugs?	<input type="checkbox"/>	<input type="checkbox"/>	11. Sinus trouble?	<input type="checkbox"/>	<input type="checkbox"/>
4. Barbiturates, sedatives or sleeping pills?	<input type="checkbox"/>	<input type="checkbox"/>	12. Lung or breathing problems?	<input type="checkbox"/>	<input type="checkbox"/>
5. Aspirin?	<input type="checkbox"/>	<input type="checkbox"/>	13. Asthma or hay fever?	<input type="checkbox"/>	<input type="checkbox"/>
6. Iodine?	<input type="checkbox"/>	<input type="checkbox"/>	14. Hives or skin rash?	<input type="checkbox"/>	<input type="checkbox"/>
7. Other? _____	<input type="checkbox"/>	<input type="checkbox"/>	15. Fainting spells or seizures?	<input type="checkbox"/>	<input type="checkbox"/>
			16. Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or have you ever had the following:			17. AIDS or HIV infection?	<input type="checkbox"/>	<input type="checkbox"/>
1. Rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>	18. Thyroid problems?	<input type="checkbox"/>	<input type="checkbox"/>
2. Scarlet fever?	<input type="checkbox"/>	<input type="checkbox"/>	19. Allergies?	<input type="checkbox"/>	<input type="checkbox"/>
3. Heart defect or heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	20. Arthritis or rheumatism?	<input type="checkbox"/>	<input type="checkbox"/>
4. Heart trouble, heart attack, or angina?	<input type="checkbox"/>	<input type="checkbox"/>	21. Joint replacement or implant?	<input type="checkbox"/>	<input type="checkbox"/>
a. Do you have pain in your chest upon exertion?	<input type="checkbox"/>	<input type="checkbox"/>	22. Stomach ulcer?	<input type="checkbox"/>	<input type="checkbox"/>
b. Are you ever short of breath after mild exercise?	<input type="checkbox"/>	<input type="checkbox"/>	23. Kidney trouble?	<input type="checkbox"/>	<input type="checkbox"/>
c. Do your ankles swell?	<input type="checkbox"/>	<input type="checkbox"/>	24. Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
d. Do you get short of breath when you lie down?	<input type="checkbox"/>	<input type="checkbox"/>	25. Persistent cough?	<input type="checkbox"/>	<input type="checkbox"/>
e. Do you require extra pillows when you sleep?	<input type="checkbox"/>	<input type="checkbox"/>	26. Cough that produces blood?	<input type="checkbox"/>	<input type="checkbox"/>
5. Pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>	27. Cancer?	<input type="checkbox"/>	<input type="checkbox"/>
6. Heart surgery?	<input type="checkbox"/>	<input type="checkbox"/>	28. Sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>
7. High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	29. Epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
			30. Anemia?	<input type="checkbox"/>	<input type="checkbox"/>
			31. Leukemia?	<input type="checkbox"/>	<input type="checkbox"/>
			32. Glaucoma?	<input type="checkbox"/>	<input type="checkbox"/>

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

Signature of Patient, Parent or Guardian _____

Date _____

For Completion by the Dentist:

Summary of Dental History:

Summary of Medical History:

Medical History Update:		Initials:		
Date	Comments	Patient	Dentist	Hygienist
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____