HEALTH HISTORY

Patient's Name_____

Date of Last Physical Exam_____ Physician's Name_____

Date of Last Dental Exam_____ Dentist's Name_____

Date of Last Dental X-Rays_____

	Yes	No
Are you having pain or discomfort at this time?	____	____
Do you feel very nervous about having dental treatment?	____	____
Have you ever had a bad experience in the dental office?	____	____
Is there anything that you dislike about your smile?	____	____
Have you been a patient in the hospital during the past two years?	____	____
Have you taken any medicines or drugs in the last two years?	____	____

Which ones?_____

Are you allergic to (itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, any drugs, medications, metals or latex?	____	____
Please explain which drugs and allergic reaction_____		
Have you ever had any excessive bleeding requiring treatment?	____	____

Check any of the following which you have had or have at present:

Heart Failure	___	Kidney Trouble	___	Arthritis	___	Diabetes	___
Heart Disease	___	Heart Attack	___	Rheumatism	___	Thyroid Disease	___
Cold Sores	___	Angina Pectoris	___	Cortisone Medicine	___	Radiation	___
Cong Heart Defects	___	High Blood Pressure	___	Emphysema	___	Blood Transfusion	___
Glaucoma	___	Epilepsy or Seizures	___	Heart Murmur	___	Hemophilia	___
Pain in Jaw Joints	___	Fainting/Dizzy Spells	___	Rheumatic Fever	___	Drug Addiction	___
Birth Defects	___	Nervousness	___	Psychiatric Treatment	___	Stroke	___
Asthma	___	Pos. HIV or AIDS	___	Sinus Trouble	___	Anemia	___
Hepatitis A	___	Artificial Heart Valve	___	Allergies/Hives	___	Alcoholism	___
Hepatitis B	___	Heart Pacemaker	___	Heart Surgery	___	Artificial Joint	___
Liver Disease	___	Use of Tobacco	___	Chemotherapy	___		

	Yes	No
Are there now any growths or sores in or around your mouth?	____	____
Do you have trouble chewing?	____	____
Do you have specific places where food catches between teeth?	____	____
Do you clench or grind your teeth?	____	____
Do you have frequent headaches or wake up with headaches?	____	____
How often do you brush?	_____XDay	
How often do you floss?	_____	
Have you ever been told you have gum problems?	____	____
Do your gums bleed when you brush or floss?	____	____
Do you use an electric toothbrush or manual toothbrush?	_____	
WOMEN: Are you pregnant now or is there any chance you are?	____	____
Are there any other medical issues you have not covered above?	____	____

Please list:_____

_____

Sign_____ **Date**_____