

HEALTH HISTORY (continued)

Yes No Unsure

10. During the last 6 months, have you taken or are you taking any medications, non-prescription drugs or herbal supplements of any kind? _____

Conditions	Drug	Dosage	Frequency Used

11. Are you on a special diet? _____

12. Have you lost or gained more than ten pounds during the last year? _____

13. Do you use any tobacco products? _____

If "Yes", please indicate:

- Cigarettes? How many per day? _____ How many years? _____
- Cigars? How many per week? _____ How many years? _____
- Pipe smoking? How many per week? _____ How many years? _____
- Chewing Tobacco How often? _____ How many years? _____

14. Do you have, or have you had any of the following diseases or conditions: _____

(Circle any that apply)

- | | | |
|----------------------------|--------------------------|-------------------------------|
| a) Cardiovascular disease | Angina | Chest Pain |
| Heart Trouble | Heart Attack | Coronary Insufficiency |
| High or Low Blood Pressure | Heart Surgery | Coronary Occlusion |
| Heart Murmur | Irregular Heart Beat | Coronary Angioplasty |
| Mitro Value Prolapse | Stroke | Arteriosclerosis |
| Congenital Heart Defect | Congestive Heart Failure | Rheumatic Fever/Scarlet Fever |

If "Yes", please describe the disease/condition: _____

b) Shortness of breath? Require extra pillows at night? _____

c) Respiratory conditions (asthma, tuberculosis, emphysema, persistent cough) _____

If "Yes", please describe: _____

e) Abnormal bleeding associated with previous extractions, surgery, or trauma _____

f) Blood disorder (such as anemia or hemophilia) _____

g) Bruise easily _____

h) Fainting or dizzy spells _____

i) Epilepsy, seizures, or convulsions _____

j) Diabetes _____

k) Hypoglycemia (Low Blood Sugar) _____

l) Liver disease; Jaundice; or Hepatitis _____

Type of Hepatitis: _____

HEALTH HISTORY (continued)

	Yes	No	Unsure
m) Kidney or bladder trouble _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) Thyroid disorder (Hypothyroid, Hyperthyroid, Goiter, Thyroid removed) __	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o) Organ transplant _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p) Arthritis or inflammatory rheumatism (painful swollen joints) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q) Joint replacement (i.e.: hip, knee) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If "Yes", describe which joint and when: _____			

r) Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If "Yes", describe when and where diagnosed, and treatment(s): _____			

s) Psychiatric conditions _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t) HIV/AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
u) Sexually transmitted disease (i.e. Syphilis, Gonorrhea, or Chlamydia) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If "Yes", describe: _____			

v) Herpes (Cold Sores) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
w) Alcohol, drug or chemical dependency _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
x) Trauma or injury to the head or neck _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If "Yes", describe when and where: _____			

15. Have you had any X-Rays (dental or medical) taken in the last year? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If "Yes", describe when / where: _____			

16. Have you received X-Ray or radioactive isotopes for treatment of disease? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Do you have, or have you had, any other condition not mentioned above? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If "Yes", please specify: _____			

Female Patients Only

18. Are you pregnant or suspect you may be pregnant? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If "Yes", when is your due date? _____			
19. Are you taking birth control pills? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Are you taking hormone replacement therapy? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Are you taking Oral or IV-administered Bisphosphonates (Fosamax, Boniva, etc.) ? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DENTAL HISTORY

22. Have you ever been advised to take antibiotics before any dental treatment? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Have you had prolonged bleeding following extractions in the past? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Are there any growths or sore spots in your mouth? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Have you ever been diagnosed with periodontal disease, gum disease, pyorrhea? ____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Do you ever have a dry or burning mouth? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HEALTH HISTORY (continued)

Yes No Unsure

27. When was your last dental visit? _____ What was done? _____

28. When was your last dental cleaning or periodontal maintenance? _____

29. Have you ever had instructions on caring for your teeth and periodontal tissues? ___

30. Have you ever been diagnosed with (or treated for) with periodontal disease? ___

31. Have you ever had an allergic reaction to “freezing”? (Local Anesthetic) _____

32. Is any part of your mouth sore due to clenching? _____

33. Have you had any difficult extractions in the past? _____

34. Do you have difficulty opening your mouth? _____

35. Do you have any current dental problems? _____

If “Yes”, please specify area: _____

Additional Health History Information:

Please initial each statement, sign and date below.

___ I certify that I read, write, and speak English.

___ I certify that I have read and fully understand the terms and words within this document, the **MEDICAL & DENTAL HEALTH HISTORY**.

___ I have accurately, truthfully and completely answered the questions on this form, to the best of my knowledge.

___ I understand that it is my responsibility to inform the dental office of any changes in my medical status.

___ I understand that providing inaccurate information on this form may be hazardous to my health.

Patient name

Patient’s signature (or responsible party/parent/guardian)

Date



MARK B. WHALEY, D.D.S.
Aesthetic & General Dentistry