



# Health History

Please fill out this form as completely as possible  
The more we know about your past health, the better we can help you stay healthy in the future

PATIENT'S NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

## MEDICAL HISTORY

PHYSICIAN'S NAME: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_\_ DATE OF LAST PHYSICAL: \_\_\_\_\_

PLEASE CHECK EITHER "YES" OR "NO" TO INDICATE IF YOU'VE HAD ANY OF THE FOLLOWING:

- |  |   |  |
|--|---|--|
| AIDS..... <input type="checkbox"/> YES <input type="checkbox"/> NO                     | EPILEPSY..... <input type="checkbox"/> YES <input type="checkbox"/> NO              | RESPIRATORY DISEASE..... <input type="checkbox"/> YES <input type="checkbox"/> NO    |
| ARTHRITIS..... <input type="checkbox"/> YES <input type="checkbox"/> NO                | FAINTING OR DIZZINESS..... <input type="checkbox"/> YES <input type="checkbox"/> NO | RHEUMATIC FEVER..... <input type="checkbox"/> YES <input type="checkbox"/> NO        |
| ARTIFICIAL HEART VALVES..... <input type="checkbox"/> YES <input type="checkbox"/> NO  | HEADACHES..... <input type="checkbox"/> YES <input type="checkbox"/> NO             | SINUS TROUBLE..... <input type="checkbox"/> YES <input type="checkbox"/> NO          |
| ARTIFICIAL JOINTS..... <input type="checkbox"/> YES <input type="checkbox"/> NO        | HEART PROBLEMS..... <input type="checkbox"/> YES <input type="checkbox"/> NO        | SKIN DISORDERS, RASHES..... <input type="checkbox"/> YES <input type="checkbox"/> NO |
| ASTHMA..... <input type="checkbox"/> YES <input type="checkbox"/> NO                   | HEPATITIS-TYPE: A B C..... <input type="checkbox"/> YES <input type="checkbox"/> NO | SPECIAL DIET..... <input type="checkbox"/> YES <input type="checkbox"/> NO           |
| BACK PROBLEMS..... <input type="checkbox"/> YES <input type="checkbox"/> NO            | HERPES..... <input type="checkbox"/> YES <input type="checkbox"/> NO                | STROKE, TIA..... <input type="checkbox"/> YES <input type="checkbox"/> NO            |
| BLEEDING-ABNORMAL LONG..... <input type="checkbox"/> YES <input type="checkbox"/> NO   | HIGH BLOOD PRESSURE..... <input type="checkbox"/> YES <input type="checkbox"/> NO   | THYROID PROBLEMS..... <input type="checkbox"/> YES <input type="checkbox"/> NO       |
| BLOOD DISEASE..... <input type="checkbox"/> YES <input type="checkbox"/> NO            | HIV POSITIVE..... <input type="checkbox"/> YES <input type="checkbox"/> NO          | TONSILITIS..... <input type="checkbox"/> YES <input type="checkbox"/> NO             |
| CANCER..... <input type="checkbox"/> YES <input type="checkbox"/> NO                   | KIDNEY DISEASE..... <input type="checkbox"/> YES <input type="checkbox"/> NO        | TUBERCULOSIS..... <input type="checkbox"/> YES <input type="checkbox"/> NO           |
| CHEMICAL/DRUG DEPENDANCE... <input type="checkbox"/> YES <input type="checkbox"/> NO   | LIVER DISEASE..... <input type="checkbox"/> YES <input type="checkbox"/> NO         | TUMORS..... <input type="checkbox"/> YES <input type="checkbox"/> NO                 |
| CHEMOTHERAPY..... <input type="checkbox"/> YES <input type="checkbox"/> NO             | LOW BLOOD PRESSURE..... <input type="checkbox"/> YES <input type="checkbox"/> NO    | ULCER..... <input type="checkbox"/> YES <input type="checkbox"/> NO                  |
| CIRCULATION PROBLEMS..... <input type="checkbox"/> YES <input type="checkbox"/> NO     | MITRAL VALVE PROLAPSE..... <input type="checkbox"/> YES <input type="checkbox"/> NO | VENEREAL DISEASE, STD..... <input type="checkbox"/> YES <input type="checkbox"/> NO  |
| CONGENITAL HEART LESIONS..... <input type="checkbox"/> YES <input type="checkbox"/> NO | NERVE PROBLEMS..... <input type="checkbox"/> YES <input type="checkbox"/> NO        | WOMEN:   |
| DIABETES..... <input type="checkbox"/> YES <input type="checkbox"/> NO                 | PACEMAKER..... <input type="checkbox"/> YES <input type="checkbox"/> NO             | ARE YOU PREGNANT?..... <input type="checkbox"/> YES <input type="checkbox"/> NO      |
| EATING DISORDERS..... <input type="checkbox"/> YES <input type="checkbox"/> NO         | PSYCHIATRIC CARE..... <input type="checkbox"/> YES <input type="checkbox"/> NO      | DUE DATE: _____  |
| EMPHYSEMA..... <input type="checkbox"/> YES <input type="checkbox"/> NO                | RADIATION TREATMENT..... <input type="checkbox"/> YES <input type="checkbox"/> NO   | ARE YOU NURSING?..... <input type="checkbox"/> YES <input type="checkbox"/> NO       |

HAVE YOU EVER BEEN TOLD TO PRE-MEDICATE BEFORE ANY DENTAL TREATMENT?.....  YES  NO IF YES, FOR WHAT REASON? \_\_\_\_\_

ARE YOU AWARE OF ANY OTHER CONDITION NOT LISTED ABOVE? \_\_\_\_\_

## MEDICATIONS

LIST ANY MEDICATIONS YOU ARE TAKING, AND THE REASON FOR TAKING IT:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## ALLERGIES

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

- |   |  |
|---|--|
| <input type="checkbox"/> ASPIRIN            | <input type="checkbox"/> LATEX             |
| <input type="checkbox"/> CLINDAMYCIN        | <input type="checkbox"/> LOCAL ANESTHETICS |
| <input type="checkbox"/> CODIENE (VICODIN)  | <input type="checkbox"/> NAPROXEN (ALEVE)  |
| <input type="checkbox"/> DARVON             | <input type="checkbox"/> NITROUS OXIDE     |
| <input type="checkbox"/> ERYTHROMYCIN       | <input type="checkbox"/> PENICILLIN        |
| <input type="checkbox"/> IBUPROFEN (MOTRIN) | <input type="checkbox"/> SULFA             |

OTHER ALLERGIES: \_\_\_\_\_

## DENTAL HISTORY

REASON FOR TODAY'S VISIT: \_\_\_\_\_

\_\_\_\_\_

DATE OF LAST DENTAL VISIT: \_\_\_\_\_

DATE OF LAST DENTAL X-RAYS: \_\_\_\_\_

USUAL FREQUENCY OF DENTAL VISITS: \_\_\_\_\_

HOW OFTEN DO YOU BRUSH?: \_\_\_\_\_

HOW OFTEN DO YOU FLOSS?: \_\_\_\_\_

HAVE YOU SEEN A SPECIALIST?  YES  NO

ARE YOU HAPPY WITH YOUR SMILE?  YES  NO

PLEASE CHECK EITHER "YES" OR "NO" TO INDICATE IF YOU'VE HAD ANY OF THE FOLLOWING:

- |                           |  |                        |  |
|---------------------------|--|------------------------|--|
| BAD BREATH OR TASTE       | <input type="checkbox"/> YES <input type="checkbox"/> NO | JAW PAIN OR TIREDNESS  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| BLEEDING GUMS             | <input type="checkbox"/> YES <input type="checkbox"/> NO | LIP OR CHEEK BITING    | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| CHIPPED OR BROKEN TEETH   | <input type="checkbox"/> YES <input type="checkbox"/> NO | LOOSE TEETH            | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| COLD SORES                | <input type="checkbox"/> YES <input type="checkbox"/> NO | MOUTH BREATHING        | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| CLENCHING OR GRINDING     | <input type="checkbox"/> YES <input type="checkbox"/> NO | ORTHODONTIC TREATMENT  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| CLICKING OR POPPING JAW   | <input type="checkbox"/> YES <input type="checkbox"/> NO | PAIN AROUND, NEAR EARS | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| CROWDED TEETH             | <input type="checkbox"/> YES <input type="checkbox"/> NO | PERIODONTAL TREATMENT  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| DISCOLORED, STAINED TEETH | <input type="checkbox"/> YES <input type="checkbox"/> NO | ROOT CANAL TREATMENT   | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| DRY MOUTH                 | <input type="checkbox"/> YES <input type="checkbox"/> NO | SENSITIVITY TO BITING  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| FINGERNAIL BITING HABIT   | <input type="checkbox"/> YES <input type="checkbox"/> NO | SENSITIVITY TO COLD    | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| FOOD TRAPS BETWEEN TEETH  | <input type="checkbox"/> YES <input type="checkbox"/> NO | SENSITIVITY TO HOT     | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| GAPS BETWEEN TEETH        | <input type="checkbox"/> YES <input type="checkbox"/> NO | SENSITIVITY TO SWEETS  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| GUMS SWOLLEN OR TENDER    | <input type="checkbox"/> YES <input type="checkbox"/> NO | TOOTHACHE PAIN         | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| HEADACHES                 | <input type="checkbox"/> YES <input type="checkbox"/> NO | TUMORS OR GROWTHS      | <input type="checkbox"/> YES <input type="checkbox"/> NO |