

HEALTH HISTORY

Client Name _____ Date of Birth _____

All health information on this form is needed to provide you with a complete diagnosis and safe dental treatment. If you do not understand any question or if you have a medical or dental condition not covered by the questions, report that information to the doctor. Incorrect or incomplete information can be dangerous to your health.

Name of Physician _____ Phone _____

Address _____

Date of Last Visit _____ Reason for Last Visit _____

1. Are you currently under the care of a physician or other health care person? If yes, for what reason or condition? _____


2. Are you currently taking any medicine? If yes, list the medicine and for what reason or condition. _____

Have You Ever Had or Been Treated For:

PLEASE WRITE IN YES OR NO

PLEASE DO NOT WRITE IN THE SPACE BELOW

- 3. Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease? _____
- 4. Heart trouble, heart attack, angina, heart surgery, a pacemaker or irregular beats? _____
- 5. Stomach or intestinal disease? _____
- 6. Abnormal blood pressure, excessive bleeding or anemia? _____
- 7. Breathing problems, asthma, tuberculosis or hay fever? _____
- 8. Cancer, X-ray treatments or chemotherapy? _____
- 9. Diabetes? _____
- 10. Hepatitis, jaundice or liver disease? _____
- 11. Kidney problems or kidney dialysis? _____
- 12. Venereal disease or AIDS? _____
- 13. A stroke, convulsions or fainting spells? _____
- 14. Do you have glaucoma? _____
- 15. Do you have implants: heart valve, knee, hip, etc? _____
- 16. Allergic reactions to medications?
 - a. Local anesthetics (novocaine or xylocaine)
 - b. Penicillin, sulpha drugs or other antibiotics
 - c. Barbiturates, sedatives or sleeping pills
 - d. Aspirin, other pain pills or narcotics like codeine
 - e. Any other medicine?
- 17. Are you pregnant? _____
- 17a. Do you take birth control pills? _____



**Medical
Alert
Sticker**

- 18. Have you had an injury to your head or neck? _____
- 19. Tumors or growths? _____
- 20. Arthritis or rheumatism? _____
- 21. Alcohol or drug dependency? _____
- 22. Do you smoke? _____
- 23. Have you consulted or been treated by psychiatrist
psychologist or counselor? _____
- 24. Have you ever had a major operation? _____
- 25. Do you have any other health problems not mentioned? _____

DENTAL HISTORY

Date of Last Visit to a Dentist _____ Do you have any of your X-rays or dental records? _____

Reason for your last visit or series of visits _____

During Previous Dental Treatment Have You:

- 26. Ever fainted? _____
- 27. Had an allergic reaction? _____
- 28. Had abnormal bleeding or other complications? _____
- 29. Do your gums bleed when brushing or eating? _____
- 30. Does food catch between your teeth? _____
- 31. Have your teeth shifted, are there spaces between your
teeth now where there were none , are some of your
teeth flaring or becoming loose? _____
- 32. Are any of your teeth sensitive to heat, cold or pressure? _____
- 33. Do you grind your teeth or clench your jaws? _____
- 34. Do you have pain or clicking in your jaw joint? _____
- 35. Have your jaw muscles ever been sore? _____
- 36. Are there any sores or growths in your mouth? _____
- 37. Do any of your teeth ache? _____
- 38. Do you have any other dental complaint? _____

Reviewed by: _____

Date: _____

I understand that the information I provide on this form is essential to determine my dental needs and to provide dental care. I understand that if any change occurs in my health I am to report it to this dental office as soon as possible. I have read and understand each question, and have answered all of them truthfully and to the best of my ability and I have discussed my health history with the doctor. I grant to Bass Lake Dental Group the right to release this and any other information about my dental care to insurance companies and/or other health care providers.

Person completing this form: Signature _____

If other than client, indicate relationship: _____ Date: _____

