



Health History

Dental History

When was your last dental visit? _____ How often do you brush your teeth? _____
 Do your gums bleed while brushing? () Yes () No
 Do you feel pain to any of your teeth when brushing or flossing them? () Yes () No
 Are your teeth sensitive to hot, cold, sweet or sour foods/liquids? () Yes () No
 Have you noticed any loosening of your teeth? () Yes () No
 Does food tend to become caught between teeth? () Yes () No
 Do you have any sores or lumps in or near your mouth? () Yes () No
 Have you ever experienced any of the following problems in your jaw?
 () Clicking () Joint Pain () Difficulty in opening or closing () Difficulty in chewing
 Have you had any head, neck, or jaw injuries? () Yes () No Do you have frequent headaches? () Yes () No
 Do you clench or grind your teeth? () Yes () No
 Have you had:
 () Orthodontic treatment () Oral surgery () Gum treatment () Your bite adjusted () Worn a bite splint
 Are you satisfied with the appearance of your teeth? () Yes () No
 Is there anything about having dental treatment that bothers you? _____

Medical History

Are you in good health? () Yes () No
 Have there been any changes in your general health within the past year? () Yes () No
 Date of your last physical exam: _____ Physician's name & phone # _____
 Are you under the care of a physician? () Yes () No
 Have you ever been hospitalized for any surgical operation or serious illness? () Yes () No
 If yes, please explain _____
 Are you taking any medication? () Yes () No If yes, please list all the medications _____

 Have you taken Fen-Phen/Redux? () Yes () No Have you had any abnormal bleeding? () Yes () No
 Do you bruise easily? () Yes () No Have you ever required a blood transfusion? () Yes () No
 Do you have a persistent cough or throat clearing not associated with a known illness? () Yes () No
 Do you use tobacco? () Yes () No Do you use alcohol? () Yes () No
 Do you use any recreational drugs? () Yes () No
 Do you have any disease, condition or problem not listed above that I should know about? _____

Women only:

Are you pregnant or think you may be pregnant? () Yes () No Are you nursing? () Yes () No
 Are you taking birth control pills? () Yes () No
 Are you **allergic** to or have you had reactions to:
 () Local anesthetics like novocaine? () Penicillin or other antibiotics? () Barbituates, sedatives or sleeping pills?
 () Aspirin () Iodine () Latex Other _____
 Do you have or have you ever had the following:
 () Rheumatic heart disease or rheumatic fever? () Heart defect or heart murmur? () Pacemaker () Cancer
 () Heart trouble, heart attack, or angina () Heart surgery () High blood pressure () Low blood pressure
 () Hepatitis, jaundice or liver disease () Stroke () Sinus Trouble () Asthma or hay fever () Hives or skin rash
 () Diabetes () AIDS or HIV () Thyroid problems () Arthritis or Rheumatism () Artificial Joint
 () Stomach Ulcer () Kidney Trouble () Tuberculosis () Sexually Transmitted Disease () Epilepsy
 Other major health conditions _____

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

Signature _____ Print _____ Date _____
 Reviewed by Doctor _____ Date _____