

HEALTH HISTORY

Patient Name _____ Birth Date _____

MEDICATIONS (Are you currently on any of the following)

NONE

- | | | | | |
|---|--|--|---|----------------------------------|
| <input type="checkbox"/> Blood thinners | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Steroids | <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Insulin |
| <input type="checkbox"/> Thyroid Medication | <input type="checkbox"/> High Blood Pressure Med | <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Acid Reflux Meds
(includes Tums, etc) | |
| <input type="checkbox"/> Herbal Supplements | <input type="checkbox"/> Oral/IV Bisphosphonates | <input type="checkbox"/> Birth Control | | |
- Other: _____

Have you ever taken Fosomax Redux Phen-Fen Controlled Substances

ALLERGIES **NONE**

- Antibiotics Latex Anesthetics (ie Novocain, Lidocain) Codeine Aspirin
 Sedatives Any Metals Sulfa Drugs Other _____

MEDICAL HISTORY Do you have, or have you ever had any of the following?

NONE

- | | | |
|---|--|--|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Anaphylaxis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Angina | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Chest Pains |
| <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Cortisone treatments |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting/Dizzy Spells | <input type="checkbox"/> Frequent Cough |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Heart Trouble/Disease |
| <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Herpes | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Acid Reflux (GERD) | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Sinus Problems |

Other Illness: _____

Pregnant, Due Date: _____

Tobacco Use Chew / Smoke Alcohol Use (more than 2 drinks per day)

Physician's Name: _____ Phone: _____

DENTAL HISTORY

Do your gums bleed when brushing Y / N

Are your teeth sensitive to hot or cold Y / N

Do you feel pain in any of your teeth? Y / N

Do you have any sores/lumps in your mouth Y / N

Have you had any head/neck/jaw injuries Y / N

Do you clench or grind your teeth Y / N

Do you have chronic bad breath Y / N

Have you ever experienced any of the following in your jaw?

- Clicking Pain in jaw/face/ear Difficulty chewing Difficulty opening/closing

Do you like the way your teeth look Yes No

Explain: _____

Would you like your teeth to be whiter Yes No

Do you have spaces between your teeth that you would like closed Yes No

Do you have missing teeth that you would like to replace Yes No

If you could change anything about your smile what would you change?

How many times per day do you brush _____ How often do you floss _____

Do you use: Electric Toothbrush ___ Water Pik ___ Nightguard ___ MI Paste ___ Fluoride ___

I certify that the above information is correct to the best of my knowledge

Patient/Guardian Signature: _____ Date: _____

Printed Name: _____

08/09