# 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: _____