HEALTH HISTORY

Name _____ **Date of Birth** _____

In case of emergency contact: _____ **at Ph. Number:** _____

Answers to the following questions are for our records only and will be considered confidential.

Date of last physical examination _____ Physician's Name _____

Date of last dental examination _____ Date of last dental x-rays _____

Previous Dentist's name _____ City/State _____

1.	Are you having pain or discomfort at this time?	**Yes**	**No**
2.	Do you feel nervous about having dental treatment?	**Yes**	**No**
3.	Have you ever had a bad experience in a dental office?	**Yes**	**No**
4.	Is there anything you dislike about your smile?	**Yes**	**No**
5.	Have you been under the care of a medical doctor during the past two years?	**Yes**	**No**
6.	Are you taking any vitamins, herbal supplements, or cures?	**Yes**	**No**
7.	Have you ever experienced any problems with your jaw?	**Yes**	**No**
8.	Have you ever had difficult extractions in the past?	**Yes**	**No**
9.	Have you ever had excessive bleeding requiring treatment?	**Yes**	**No**
10.	Do you habitually clench or grind your teeth during the day or night?	**Yes**	**No**
11.	Have you ever been told you have gum problems?	**Yes**	**No**
12.	Have you ever taken Redux or Pandimin (Fen Phen)?	**Yes**	**No**
13.	Have you ever taken Bisphosphonates?	**Yes**	**No**

ALLERGIES (Please Circle)

Aspirin
Barbiturates
Codeine
Iodine
Latex
Local Anesthetic
Penicillin
Sulfa
Metals
Other:_____

MEDICATIONS

Please list medications you are currently taking **and** what they are taken for.

_____

_____

_____

_____

Pharmacy: _____

Place a mark on yes or no to indicate if you have had any of the following:

Alcoholism	**Yes**	**No**	Eating Disorder	**Yes**	**No**	HIV positive, ARC, AIDS	**Yes**	**No**
Anemia	**Yes**	**No**	Emphysema	**Yes**	**No**	*Any type of implant	**Yes**	**No**
Angina Pectoris	**Yes**	**No**	Epilepsy or Seizures	**Yes**	**No**	Jaundice	**Yes**	**No**
Asthma	**Yes**	**No**	Fainting or Dizzy spells	**Yes**	**No**	Kidney trouble	**Yes**	**No**
Arthritis	**Yes**	**No**	Glaucoma	**Yes**	**No**	Liver Disease	**Yes**	**No**
*Artificial Joint	**Yes**	**No**	Hay Fever	**Yes**	**No**	*Mitral Valve Prolapse	**Yes**	**No**
Back problems	**Yes**	**No**	Heart Disease or Attack	**Yes**	**No**	Osteoporosis	**Yes**	**No**
Blood Transfusion	**Yes**	**No**	Heart Failure	**Yes**	**No**	Persistent Cough	**Yes**	**No**
Bruise easily	**Yes**	**No**	*Heart Murmur	**Yes**	**No**	Psychiatric treatment	**Yes**	**No**
Cancer (Type) _____	**Yes**	**No**	Heart pacemaker	**Yes**	**No**	*Rheumatic Fever	**Yes**	**No**
(Date) _____			Heart Problems	**Yes**	**No**	Shortness of Breath	**Yes**	**No**
Chemotherapy	**Yes**	**No**	Heart Surgery	**Yes**	**No**	Sickle Cell disease	**Yes**	**No**
Radiation therapy	**Yes**	**No**	Hemophilia	**Yes**	**No**	Sinus trouble	**Yes**	**No**
Chest Pain	**Yes**	**No**	Hepatitis A (Infectious)	**Yes**	**No**	*Steroid treatment	**Yes**	**No**
Cold Sores	**Yes**	**No**	Hepatitis B (Serum)	**Yes**	**No**	Stroke	**Yes**	**No**
*Congenital Heart Problems	**Yes**	**No**	Hepatitis C or other	**Yes**	**No**	*Any type of Transplant	**Yes**	**No**
Dentures or Partials	**Yes**	**No**	Herpes	**Yes**	**No**	Thyroid Disease	**Yes**	**No**
Diabetes	**Yes**	**No**	High Blood Pressure	**Yes**	**No**	Use of Tobacco products	**Yes**	**No**
Drug addiction	**Yes**	**No**	Hives or skin rash	**Yes**	**No**	Tuberculosis (TB)	**Yes**	**No**

***Antibiotic pre-medication may be required prior to your appointment.**

Do you wear contact lenses? **Yes** **No**

WOMEN: Are you pregnant now? **Yes** **No** If yes, what is your due date? _____

Are you currently breast-feeding? **Yes** **No**

Are you taking oral contraceptives? **Yes** **No**

Signature: _____ **Date:** _____