PATIENT HEALTH HISTORY

How would you describe your health? _____

Name of physician _____ Date of last Medical Exam: _____

	Yes	No
1. Are you now or have you been under the care of a physician within the past five years? If so, why? _____	☐	☐
2. Have you had any major surgery or hospitalization? _____ date _____	☐	☐
3. Are you now or have you recently been taking any medication? If so, for what? _____	☐	☐
4. Are you taking any bisphosphonates for cancer treatment or osteoporosis? _____	☐	☐
5. Have you taken Phen-fen before? When? _____ Have you seen your physician after that? _____	☐	☐

6. Are you allergic to or have any reactions to any of the following: *(mark each applicable box)*

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Local Anesthetics (e.g. Novocaine)	☐	☐	Aspirin	☐	☐	Iodine	☐	☐	Others (please list) _____
☐	☐	Penicillin or any other antibotics _____	☐	☐	Codeine	☐	☐	Any metals (e.g. nickel, mercury)	☐	☐	_____
		_____	☐	☐	Barbituates	☐	☐	Latex rubber	☐	☐	
☐	☐	Sulfa Drugs	☐	☐	Sedatives						

6. **WOMEN ONLY:**	Yes	No
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

7. **DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:** *(mark each applicable box)*

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Heart Attack	☐	☐	Joint Replacement/Implant	☐	☐	Cortisone Medicine	☐	☐	Gonorrhea
☐	☐	Heart Failure	☐	☐	Kidney Trouble	☐	☐	Glaucoma	☐	☐	Cold Sores
☐	☐	Heart Surgery	☐	☐	Ulcers	☐	☐	Pain in Jaw Joints	☐	☐	Genital Herpes
☐	☐	Heart Disease	☐	☐	Arthritis	☐	☐	Epilepsy or Seizures	☐	☐	Fainting / Dizzy Spells
☐	☐	Angina Pectoris	☐	☐	Empysema	☐	☐	Aids or HIV Infection	☐	☐	Nervousness
☐	☐	Heart Murmur	☐	☐	Tuberculosis	☐	☐	Hepatitis A (infectious)	☐	☐	Psychiatric Treatment
☐	☐	High Blood Pressure	☐	☐	Asthma	☐	☐	Hepatitis B (serum)	☐	☐	Sickle Cell Disease
☐	☐	Rheumatic Fever	☐	☐	Hay Fever/Allergies	☐	☐	Liver Disease	☐	☐	Bleeding Gums
☐	☐	Congential Heart Defect	☐	☐	Sinus Trouble	☐	☐	Yellow Jaundice	☐	☐	Tooth Pain
☐	☐	Scarlet Fever	☐	☐	Diabetes	☐	☐	Blood Transfusion	☐	☐	Bad Breath
☐	☐	Artificial Heart Valve	☐	☐	Thyroid Disease	☐	☐	Drug Addiction	☐	☐	Chronic Headaches
☐	☐	Mitral Valve Prolapse	☐	☐	Radiation Treatment	☐	☐	Hemophilia	☐	☐	Chronic Neckaches
☐	☐	Heart Pace Maker	☐	☐	Chemotherapy	☐	☐	Syphilis	☐	☐	Cosmetic Surgery
☐	☐	Stroke	☐	☐	Cancer	☐	☐	Leukemia	☐	☐	Others not listed: _____

PATIENT DENTAL HISTORY

Name of Previous Dentist and Location _____ Date of Last Exam _____

	YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, date of placement _____	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners.

Signature of Patient/Parent or Guardian: _____ Date _____

Doctor's Comments: _____

_____

_____ Doctor's Signature _____ Date _____