

# HEALTH HISTORY

**PATIENT NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**DENTAL HISTORY:**

Reason for today's visit \_\_\_\_\_

Former Dentist \_\_\_\_\_ City/State \_\_\_\_\_

- Are you feeling any pain/discomfort with your teeth? Where? \_\_\_\_\_ yes no
- Do you think you have active decay or gum disease? \_\_\_\_\_ yes no
- Do you feel nervous about dental treatment? \_\_\_\_\_ yes no
- What can we do to alleviate your nervousness? \_\_\_\_\_
- Have you ever had a bad experience in a dental office? \_\_\_\_\_ yes no
- What can we do to make this experience better for you? \_\_\_\_\_
- Does food catch between your teeth? \_\_\_\_\_ yes no

**MEDICAL HISTORY:**

- Are you under a doctor's care now? \_\_\_\_\_ yes no
- Have you been hospitalized or received a blood transfusion? \_\_\_\_\_ yes no
- Are you taking any medications, pills, or drugs? \_\_\_\_\_ yes no
- Please list: \_\_\_\_\_
- Are you allergic to any medications or substances? Please respond below: \_\_\_\_\_ yes no
  - Penicillin  Tetracycline  Sulfa Drugs  Any Rubber Products (e.g. Latex)
  - Codeine  Ibuprofen (e.g. Advil, Motrin)  Aspirin  Other \_\_\_\_\_
- Are you pregnant? Delivery date? \_\_\_\_\_ Nursing? \_\_\_\_\_ yes no

**Please check YES or NO to the following:**

	y	n		y	n		y	n
Heart Trouble.....	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath.....	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever.....	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Swelling Feet/Ankles/Hands...	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizziness.....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Cough.....	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Lesion.....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve.....	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints/Hips.....	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Trouble.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A/B.....	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>
Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss...	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily.....	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion..	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia.....	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care.....	<input type="checkbox"/>	<input type="checkbox"/>	AIDS (HIV+).....	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction.....	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease...	<input type="checkbox"/>	<input type="checkbox"/>
Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Gout.....	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures...	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism.....	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness.....	<input type="checkbox"/>	<input type="checkbox"/>
Parathyroid Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joints.....	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores.....	<input type="checkbox"/>	<input type="checkbox"/>
X-ray or Cobalt Treatment...	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Medicine.....	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters.....	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy/Radiation....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	Herpes.....	<input type="checkbox"/>	<input type="checkbox"/>
Phen-Phen.....	<input type="checkbox"/>	<input type="checkbox"/>	Headaches.....	<input type="checkbox"/>	<input type="checkbox"/>		y	n
							<input type="checkbox"/>	<input type="checkbox"/>
							y	n
							<input type="checkbox"/>	<input type="checkbox"/>

**Note to Women:** Antibiotics (such as Penicillin) may alter the effectiveness of birth control pills. Consult your physician or gynecologist for assistance regarding additional or alternative methods of birth control.

X \_\_\_\_\_ To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

**Patient Signature (Parent or Guardian)**

Reviewed by: Doctor \_\_\_\_\_ Date: \_\_\_\_\_

Date _____	Changes _____	Patient Signature _____	Reviewed By _____
_____	_____	None <input type="checkbox"/> _____	Dr. _____
_____	_____	None <input type="checkbox"/> _____	Dr. _____

Doctor's notes