Health History Form

Name _____ Birth date _____

Please check any of the following problems that apply to you.

____Sensitivity (hot, cold, sweet)
____Tooth pain or discomfort when chewing
____Headaches, earaches, neck pain
____Jaw Joint Pain
____Teeth or fillings breaking
____Grinding or clenching teeth
____Bleeding, swollen or irritated gums
____Loose, tipped or shifting teeth
____Bad breath or bad taste in your mouth

Do you have or have you had any of the following

___Dentures ____Partial Dentures ___Braces
___Periodontal (gum) Treatments

Are you interested in any cosmetic treatments, including

____Whitening ____Straightening ____Full Smile makeovers
____Replacing old Silver fillings ____Repair missing teeth
____Fixing chipped or broken teeth ____INVISALIGN
OTHER_____

Name of Previous Dentist_____ Phone #_____
Reason for leaving previous Dentist_____
What is the most important thing about your Dental Visit Today?_____
Date of Last Cleaning ___ / ___ Date of Last x-rays ___ / ___

MEDICAL HISTORY

Do you smoke or use chewing tobacco? Yes NO Have You ever had an Intra-oral Cancer Exam? Yes NO
How much? _____ For how long? _____ Would you Like to Have one at your Dental Visit? Yes NO

Please check any of the following that apply to you:

Acid Reflux	Diabetes	Hepatitis C	Radiation (head/neck)
AIDS	Dizziness	High Blood Pressure	Respiratory Problems
Allergies (Seasonal)	Drug Addiction	HIV Positive	Rheumatic Fever
Allergic to Latex	Emphysema	Jaundice	Rheumatism
Anemia	Excessive Bleeding	Jaw Joint Pain	Scarlet Fever
Arthritis	Fainting	Kidney Disease	Seizures
Artificial Heart Valve	Glaucoma	Liver Disease	Stomach Problems
Artificial Joints	Heart Conditions	Low Blood Pressure	Stroke
Asthma	Heart Lesions (Congenital)	Mitral Valve Prolapse	Thyroid Disease
Blood Disease	Heart Murmur	Nervousness/Depression	Tuberculosis
Bruise Easily	Heart Surgery	Pacemaker	Ulcers
Cancer	Hepatitis A	Phen Fen (1 month +)	Venereal Diseases
Chemotherapy	Hepatitis B	Pregnant Currently	Other_____

Do you have any of the following drug allergies?

Aspirin	Codeine
Darvon	Erythromycin
Nitrous Oxide	Valium
Percodan	Penicillin
Local Anesthetic	Other_____

Are you currently under a physician's care? What for?

_____

Are you taking any medications? List them below

_____

_____

Family Physician / Phone Number _____

_____

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any changes in my health or change in my medication, I will inform the dentist at the next appointment.

_____ _____
Signature of Patient (Parent/Legal Guardian) Date

_____ _____
Signature of Dentist Date