HEALTH HISTORY

PATIENT'S NAME:___________________________________ DATE_____________

In our office we like to treat people and not just teeth! We would like to give you dental care tailored to your individual needs and ask that you aid us in answering the following questions as completely as possible. Please remember that all of your records are held in strict confidence, and cannot be released to anyone without your written notice.

DENTAL HISTORY

Tell us what we can do for you today____

Date of last dental visit:____________________ Last cleaning:_________________ Last x-rays:________________

Name of former dentist:_____________________________________Phone number:__________________________

What did you like and not like about your previous dental care:____________________________________
____

Have you ever had a bad experience at the dentist? ____
____

Is there anything that concerns you about your mouth/gums/teeth/smile? ______________________________
____

What could we do to give you perfect dental visits: ____

How often do you brush? _____________________ How often do you floss? ____________________________

Do you have any of the following:

	Y	N		Y	N
Bad breath			Clicking / Popping of jaw................................		
Bleeding / sore gums			Sensitivity to hot / cold		
Loose teeth			Sensitivity to sweets		
Dry mouth			Sensitivity when biting		
Wisdom teeth removed			Periodontal treatment / Gum treatment		
Blisters / Canker sores...............................			Orthodontic treatment..		
Discolorations in mouth			Jaw Surgery / Tooth removal		
Grinding / Clenching of teeth....................			Dental Implants		

DRUG ALLERGIES

Do you have reactions or allergies to any of the following:

	Y	N		Y	N
Codiene			Dental anesthetic (novacaine, etc…)		
Barbituates			Nitrous oxide (laughing gas).........................		
Penicillin.............................			Latex		
Erythromycin.......................			Others ________________________________		
Sulfa Drugs			________________________________		
Aspirin					

MEDICATIONS

Please list any prescription or non prescription medication you currently take (or are supposed to be taking), dosage, and for what condition:

Medication	Dosage	Medication	Dosage
______________	________	______________	________
______________	________	______________	________
______________	________	______________	________
______________	________	______________	________

Have you taken Cortisone or any other steroids in the past 12 months?______________________________

Recreational drugs can also interfere with your dental health and anesthetics we may use during your treatment. Please inform us before treatment if any have been used within a week of your appointments.

MEDICAL HISTORY

Do you have or have you had any of the following:

	Y	N		Y	N
Heart disease / failure / attack			Hepatitis (Type________)..		
Angina pectoris / chest pains			Liver disease / cirrhosis / jaundice.....................................		
Pacemaker / defibrillator			Stomach problems / ulcers		
High / low blood pressure			Sinus trouble		
Rheumatic fever			Breathing difficulties		
Congenital heart defect / murmur			Asthma / emphysema...		
Artificial heart valve..(Year replaced ______)..........			Tuberculosis..		
Mitral valve prolapse/heart murmur			Arthritis..		
Stroke / aneurysm			Artificial joint (hip, knee, etc)…(Year replaced ________)		
Other heart problem__________________________			Diabetes…......................…………(Type ____________)		
Blood transfusion (Date________)			Thryoid disease..		
Anemia / Sickle cell disease			Kidney problems / failure / dialysis………………………..		
Abnormal bleeding or healing			Drug / alcohol addiction		
Fainting / dizzy spells			Cancer / tumor.....(Type_________________/Year______)		
Severe headaches			Radiation / x-ray treatment		
Epilepsy / seizures / convulsions			Chemotherapy...		
HIV positive / AIDS			Autoimmune disorder (MS, Lupus, etc)............................		
Possible exposure to communicable diseases............			Frequent nose bleeds		
Veneral disease / STD...			WOMEN: Are you pregnant or nursing		
Transplant.......(Type_______________/Year______)			Do you use tobacco products?…........…(Type_________)		
Glaucoma					

Have you had any operations, surgery or been hospitalized?______________________________

Do you have any other condition that would be of value to know:______________________________

Name of family physician:______________________________ Phone number:__________________

Date of last visit with physician:_______________

Dentist's comments:______________________________

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PATIENT'S SIGNATURE______________________________ **DATE**______________

DENTIST'S SIGNATURE______________________________ **DATE**______________

Medical updates: Date____________ Date_____________ Date_____________ Date_____________ Date___________