

Please fill out the following information and sign at the bottom of the back page

# HEALTH DATA (confidential)

PATIENT NAME \_\_\_\_\_

D.O.B. \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 mo            date            yr

## MEDICAL HISTORY

(PLEASE ANSWER EACH QUESTION CHECK YES OR NO. IF IN DOUBT, LEAVE BLANK)

1. Reason for dental visit? \_\_\_\_\_ YES    NO
2. Are you in good health now? .....
3. Are you now under the care of a physician? .....       
 If so, what is the condition being treated? \_\_\_\_\_
4. Have you ever been hospitalized or had a serious illness? .....       
 If yes explain: \_\_\_\_\_
5. Have you ever had excessive bleeding following an extraction or do cuts take longer to heal now than previously? ...
6. (Women) Are you or maybe pregnant? If so, due date \_\_\_\_\_
7. Do you smoke or use any tobacco products? If so, amount \_\_\_\_\_
8. Do you use alcoholic beverages? (More than 2 drinks per day) .....

### 9. Have you ever had or experienced any of the following (please answer questions below)

GENERAL	YES	NO	RESPIRATORY	YES	NO	DIGESTIVE SYSTEM	YES	NO
Tire easily, weakness.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>
Marked weight change....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice (yellow).....	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats.....	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/ hay fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>
Persistent Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough.....	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorders.....	<input type="checkbox"/>	<input type="checkbox"/>
			Sputum production .....	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Vomiting.....	<input type="checkbox"/>	<input type="checkbox"/>
			Cough up bloody sputum....	<input type="checkbox"/>	<input type="checkbox"/>	Bloody/ brown vomitus	<input type="checkbox"/>	<input type="checkbox"/>
			Difficulty breathing while			Black, bloody stools....	<input type="checkbox"/>	<input type="checkbox"/>
			lying down.....	<input type="checkbox"/>	<input type="checkbox"/>	Frequent diarrhea.....	<input type="checkbox"/>	<input type="checkbox"/>
<b>SKIN</b>			<b>HEART/ BLOOD VESSELS</b>			<b>URINARY</b>		
Eruptions (rash) hives....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Change in skin color.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urine (night)...	<input type="checkbox"/>	<input type="checkbox"/>
			Chest pain/ discomfort.....	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine.....	<input type="checkbox"/>	<input type="checkbox"/>
			Heart attack/ trouble.....	<input type="checkbox"/>	<input type="checkbox"/>	Burning on urination....	<input type="checkbox"/>	<input type="checkbox"/>
			Shortness of breath.....	<input type="checkbox"/>	<input type="checkbox"/>	Urethral discharge.....	<input type="checkbox"/>	<input type="checkbox"/>
			Swelling of ankles.....	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease.....	<input type="checkbox"/>	<input type="checkbox"/>
			High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis.....	<input type="checkbox"/>	<input type="checkbox"/>
			Congenital heart disease....	<input type="checkbox"/>	<input type="checkbox"/>			
<b>EYES</b>			Artificial heart valve.....	<input type="checkbox"/>	<input type="checkbox"/>	<b>BLOOD</b>		
Visual change.....	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding tendency.....	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	Other.....	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily.....	<input type="checkbox"/>	<input type="checkbox"/>
						Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>
						Blood transfusions.....	<input type="checkbox"/>	<input type="checkbox"/>
						HIV+/AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>
<b>EARS</b>			<b>ENDOCRINE</b>					
Loss of hearing.....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	<b>OTHER</b>		
Ringing in ears.....	<input type="checkbox"/>	<input type="checkbox"/>	Family history of diabetes...	<input type="checkbox"/>	<input type="checkbox"/>	Chemo therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
			Thyroid condition/ goiter....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
			Other.....	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or growths.....	<input type="checkbox"/>	<input type="checkbox"/>
						Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>
						Fen-Phen.....	<input type="checkbox"/>	<input type="checkbox"/>
<b>NOSE</b>			<b>BONE/MUSCLES</b>					
Frequent nose bleeds.....	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Rheumatism.....	<input type="checkbox"/>	<input type="checkbox"/>			
Sinus problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joints.....	<input type="checkbox"/>	<input type="checkbox"/>			
<b>THROAT</b>								
Soreness/ hoarseness .....	<input type="checkbox"/>	<input type="checkbox"/>						
<b>NERVOUS SYSTEM</b>								
Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>						
Headaches.....	<input type="checkbox"/>	<input type="checkbox"/>						
Epilepsy/Convulsions.....	<input type="checkbox"/>	<input type="checkbox"/>						
Numbness/ tingling .....	<input type="checkbox"/>	<input type="checkbox"/>						
Dizziness/ fainting.....	<input type="checkbox"/>	<input type="checkbox"/>						
Psychiatric treatment .....	<input type="checkbox"/>	<input type="checkbox"/>						

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**10. Are you ALLERGIC or have ever experienced any reaction to the following?**

	YES	NO		YES	NO		YES	NO
Local anesthetics (Novocaine)...	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin.....	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin.....	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates /sedatives .....	<input type="checkbox"/>	<input type="checkbox"/>	Other antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa drugs.....	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping pills .....	<input type="checkbox"/>	<input type="checkbox"/>	Codeine.....	<input type="checkbox"/>	<input type="checkbox"/>	Other.....	<input type="checkbox"/>	<input type="checkbox"/>

**11. Have you taken any of the following medications within the last 3 months:**

	YES	NO		YES	NO		YES	NO
Antibiotics/sulfa drugs.....	<input type="checkbox"/>	<input type="checkbox"/>	Recreational drugs .....	<input type="checkbox"/>	<input type="checkbox"/>	Heart medications.....	<input type="checkbox"/>	<input type="checkbox"/>
Blood Thinners.....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid medicine.....	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone/Steroids.....	<input type="checkbox"/>	<input type="checkbox"/>
Tranquilizers.....	<input type="checkbox"/>	<input type="checkbox"/>	Nitroglycerin.....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes drugs .....	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure medication.....	<input type="checkbox"/>	<input type="checkbox"/>	Antihistamines/allergy			Birth Control Pills.....	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin.....	<input type="checkbox"/>	<input type="checkbox"/>	drugs/cold remedies ...	<input type="checkbox"/>	<input type="checkbox"/>	Other .....	<input type="checkbox"/>	<input type="checkbox"/>

**If YES to any of the above, list names of medication and dosage below:**

<u>Name</u>	<u>Dosage</u>	<u>Name</u>	<u>Dosage</u>
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

12. Is there any disease, condition or problem not listed above that you think we should know about or is there any activity your doctor says you cannot do?..... **YES** **NO**  
   
 If so, explain \_\_\_\_\_

13. Name and address of your (Medical Doctor) \_\_\_\_\_ Physician's Phone # \_\_\_\_\_

**DENTAL HISTORY**

	YES	NO
1. Do you like your smile?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Would you like to change the appearance of your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you had ortho treatment (braces)?.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you had wisdom teeth extractions?.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever been treated for periodontal disease (gum disease, scaling root planning, pyorrhea, trench mouth)?.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any serious trouble associated with any previous dental treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>
If so explain _____		
7. Does dental treatment make you nervous? None_____ Lightly _____ Moderate_____ Extremely_____		
8. Date of last dental visit _____ Last Dental x-rays _____		

**Have you had any of the following?**

<b>MOUTH</b>	YES	NO	<b>TEETH</b>	YES	NO	<b>ORAL HYGIENE</b>	YES	NO
Bleeding, sore gums.....	<input type="checkbox"/>	<input type="checkbox"/>	Loose teeth.....	<input type="checkbox"/>	<input type="checkbox"/>	Brush.....	<input type="checkbox"/>	<input type="checkbox"/>
Unpleasant taste/bad breath.....	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to hot.....	<input type="checkbox"/>	<input type="checkbox"/>	How often _____		
Burning tongue/lips.....	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to cold.....	<input type="checkbox"/>	<input type="checkbox"/>	Duration (mins) _____		
Frequent blisters, lips.....	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to biting.....	<input type="checkbox"/>	<input type="checkbox"/>	Dental Floss.....	<input type="checkbox"/>	<input type="checkbox"/>
Swelling/lumps in mouth.....	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to sweets .....	<input type="checkbox"/>	<input type="checkbox"/>	Water Flosser.....	<input type="checkbox"/>	<input type="checkbox"/>
Biting Cheeks/lips.....	<input type="checkbox"/>	<input type="checkbox"/>	Food impaction.....	<input type="checkbox"/>	<input type="checkbox"/>	Tongue Scraper.....	<input type="checkbox"/>	<input type="checkbox"/>
Clicking/popping jaw.....	<input type="checkbox"/>	<input type="checkbox"/>	Clenching./Grinding.....	<input type="checkbox"/>	<input type="checkbox"/>	Fluoride rinse.....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty opening/closing jaw.....	<input type="checkbox"/>	<input type="checkbox"/>	Shifting of teeth.....	<input type="checkbox"/>	<input type="checkbox"/>	Desensitize toothpaste..	<input type="checkbox"/>	<input type="checkbox"/>
Pain ( jaw, ear, side of face).....	<input type="checkbox"/>	<input type="checkbox"/>	Change in bite.....	<input type="checkbox"/>	<input type="checkbox"/>	Other.....	<input type="checkbox"/>	<input type="checkbox"/>

**I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency, who may release such information to you. I will notify my dentist of any changes in my health or medication.**

\_\_\_\_\_  
Signature of Patient, Parent, or Guardian

\_\_\_\_\_  
Parent or Guardian-Print name

\_\_\_\_\_  
Dr. Signature

\_\_\_\_\_  
Date