

HEALTH HISTORY

Correct answer to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name _____ Birthdate _____ Age _____

Why are you now seeking dental treatment?

Please answer each question. Circle yes or no. If in doubt leave blank.

1. Are you in good health now? Yes No
2. Are you now under the care of a physician? Yes No
If so, what is the condition being treated? _____
3. Have you ever been hospitalized or had a serious illness? Yes No
If yes explain _____
4. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously? Yes No
5. (Women) Are you pregnant? If so, give due date _____ Yes No
6. Do you use tobacco in any form? If yes, how much? _____ Yes No
7. Do you use alcoholic beverages (more than 2 per day)? Yes No
8. Do you have or have you ever had any of the following?

GENERAL

Tire easily, weakness Yes No
 Marked weight change Yes No
 Night sweats Yes No
 Persistent fever Yes No

SKIN

Eruptions (rash) hives Yes No
 Change in skin color Yes No

EYES

Visual Change Yes No
 Glaucoma Yes No

EARS

Loss of hearing Yes No
 Ringing in ears Yes No

NOSE

Frequent nosebleeds Yes No
 Sinus problems Yes No

THROAT

Soreness/hoarseness Yes No

NERVOUS SYSTEM

Stroke Yes No
 Headaches Yes No
 Convulsions/epilepsy Yes No
 Numbness/tingling Yes No
 Dizziness/fainting Yes No
 Psychiatric treatment Yes No

RESPIRATORY

Tuberculosis Yes No
 Emphysema Yes No
 Asthma/hay fever Yes No
 Persistent cough Yes No
 Sputum production (Phlegm) Yes No
 Cough up bloody sputum Yes No
 Difficulty breathing lying down Yes No

ENDOCRINE

Diabetes Yes No
 Family history of diabetes Yes No
 Thyroid condition/goiter Yes No
 Other _____

HEART/BLOOD VESSELS

Rheumatic Fever Yes No
 Heart Murmur Yes No
 Chest pain/discomfort Yes No
 Heart attack/trouble Yes No
 Shortness of Breath Yes No
 High Blood Pressure Yes No
 Congenital heart disease Yes No
 Artificial heart valve Yes No
 Pacemaker Yes No
 Heart Surgery Yes No
 Other _____

BONE/MUSCLES

Arthritis/rheumatism Yes No
 Artificial joints Yes No

DIGESTIVE SYSTEM

Hepatitis Yes No
 Jaundice Yes No
 Ulcers Yes No
 Change in appetite Yes No
 Black, bloody or pale stools Yes No

URINARY

Kidney disease Yes No
 Increase in frequency of urination (night) Yes No
 Burning on urination Yes No
 Urethral discharge Yes No
 Bloody urine Yes No
 Venereal disease Yes No

BLOOD

Bruise easily Yes No
 Anemia Yes No
 Blood transfusion Yes No

OTHER

Radiation therapy Yes No
 Tumors or growths Yes No
 Cancer Yes No
 AIDS Yes No

9. Do you take birth control pills? Yes No

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

Local anesthetics (e.g. Novocain)	Yes	No	Aspirin or codeine	Yes	No
Barbiturates/sedatives/sleeping pills	Yes	No	Sulfa drugs	Yes	No
Penicillin/other antibiotics	Yes	No	Other allergies _____		

11. Are you taking any of the following?

Antibiotics/sulfa drugs	Yes	No	Tranquilizers	Yes	No
Blood thinners	Yes	No	Insulin/other diabetes drugs	Yes	No
Blood pressure medication	Yes	No	Recreational drugs	Yes	No
Thyroid medication	Yes	No	Digitalis/other heart medications	Yes	No
Cortisone/steroids	Yes	No	Nitroglycerin	Yes	No
Antihistamine/allergy drugs	Yes	No	Aspirin	Yes	No
Cold remedies	Yes	No	Other medication _____		

If yes to any of the above, list *name* of medication and *dosage* below:

1. _____
2. _____
3. _____
4. _____

1. 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? If so, explain _____

2. Physician's Name _____ Phone _____

12. Have you ever had any serious trouble associated with previous dental treatment? Yes No
If so, explain _____

13. Does dental treatment make you nervous? No Slightly Moderately Extremely

14. Date of last dental visit _____

15. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? Yes No
If so, when? _____

16. Do you have or have you ever had any of the following?

MOUTH

Bleeding, sore gums	Yes	No
Unpleasant taste/bad breath	Yes	No
Burning tongue/lips	Yes	No
Frequent blister, lips/mouth	Yes	No
Swelling/lumps in mouth	Yes	No
Ortho treatments (braces)	Yes	No
Biting cheeks/lips	Yes	No
Clicking/popping jaw	Yes	No
Difficulty opening or closing jaw	Yes	No

TEETH

Loose teeth	Yes	No
Sensitive to hot	Yes	No
Sensitive to cold	Yes	No
Sensitive to sweets	Yes	No
Sensitive to biting	Yes	No
Food impaction	Yes	No
Clenching/grinding	Yes	No
Shifting of teeth	Yes	No
Change in bite	Yes	No

ORAL HYGIENE

Do you use the following?

Brush	Yes	No
Dental floss	Yes	No
Fluoride rinse	Yes	No
Other _____		

How often do you brush _____
Brush is: soft medium hard

Height _____ Weight _____