Health History Form

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

Name _____Birth date_____ 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 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, please 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. Doyou use tobacco in any form? If yes, how much _____ YES NO
7. Do you use alcoholic beverages (more than 2 drinks per day)? ..... YES NO
8. Do you have or have you ever had any of the following? Please circle any that apply.

GENERAL
Marked weight change
Night sweats
Persistent fever

SKIN
Eruptions (rash) hives
Change in skin color

EYES
Visual change
Glaucoma

EARS
Loss of hearing
Ringing in ears

NOSE
Frequent nosebleeds
Sinus problems

THROAT
Soreness/hoarseness

BLOOD
Bruise easily
Anemia
Blood transfusion

BONE/MUSCLES
Arthritis/rheumatism
Artificial joints/limbs

HEART/BLOOD VESSELS
Rheumatic fever
Heart murmur
Chest pain/discomfort
Heart attack/trouble
Shortness of breath
Swelling of ankles
High blood pressure
Congenital heart disease
Mitral valve prolapse
Artificial heart valve
Pacemaker
Heart surgery
Other

RESPIRATORY
Tuberculosis
Emphysema
Asthma/hay fever
Persistent cough
Sputum production (phlegm)
Cough up bloody sputum
Difficulty breathing
while lying down

ENDOCRINE
Diabetes
Family history of diabetes
Thyroid condition/goiter
Other

DIGESTIVE SYSTEM
Hepatitis
Jaundice
Ulcers
Change in appetite
Black, bloody or pale stools

URINARY
Kidney disease
Increase in frequency
of urination(night)
Burning on urination
Urethral discharge
Bloody urine
Venereal disease

OTHER
Latex Sensitivity
Radiation therapy
Chemotherapy
Tumors or growths
Cancer
HIV+
AIDS

NERVOUS SYSTEM
Stroke
Headaches
Convulsions/epilepsy
Numbness/tingling
Dizziness/fainting
Psychiatric treatment

9. Are you 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 _____		

10. 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 medicine	YES	NO	Digitalis/other heat medication	YES	NO
Cortisone/ steroids	YES	NO	Nitroglycerin	YES	NO
Antihistamines/allergy drugs/			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. _____

11. 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, please explain_____

12. Physician's Name _____

13. Have you ever had any serious trouble associated with previous dental treatment? _____

14. Does dental treatment make you nervous? No _____ Slightly _____ Moderate_____ Extremely _____

15. Date of last dental visit _____

16. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)?_____

If so, when? _____

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

MOUTH			**TEETH**		
Bleeding, sore gums	YES	NO	Loose teeth	YES	NO
Unpleasant taste/bad breathe	YES	NO	Sensitive to hot	YES	NO
Burning tongue/lips	YES	NO	Sensitive to cold	YES	NO
Frequent blisters, lips/mouth	YES	NO	Sensitive to sweets	YES	NO
Swelling/lumps in mouth	YES	NO	Sensitive to biting	YES	NO
Ortho treatments (braces)	YES	NO	Food impaction	YES	NO
Biting cheeks/lips	YES	NO	Clenching/grinding	YES	NO
Clicking/popping jaw	YES	NO	Shifting of teeth	YES	NO
Difficulty opening or closing jaw	YES	NO	Change in bite	YES	NO

ORAL HYGIENE

Do you use the following?

Brush	YES	NO	How often do you brush _____
Dental floss	YES	NO	Brush is: Soft _____ Medium _____ Hard _____
Fluoride rinse	YES	NO	

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

Signature of Patient
Parent or Guardian _____Date_____