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A detailed health history is important as an aid to your treatment. Please answer all questions yes or no. If you have questions, please ask us.

Name _____ Date of Birth _____
General Physician _____ Phone _____
Address _____ Date Last Visit _____
Medical Specialist(s)_____ Phone _____
Address _____ Date Last Visit _____
Previous Dentist _____ Phone _____
Address _____ Date Last Visit _____

Dental History

1. Do you want complete dental care, or is this a problem-focused visit? (circle)		
2. Is there anything you would like to change about your smile?	Y	N
3. Are you worried or anxious about dental treatment?	Y	N
4. Do you have sensitive teeth (hot / cold / sugar / biting--circle)	Y	N
5. Do you have bleeding gums? (spontaneous / brushing / flossing)	Y	N
6. Do you get cold sores (usually on lips--takes 10 days to heal)	Y	N
7. Do you have trouble and/or pain on opening your mouth wide?	Y	N
8. Have you had severe jaw joint clicks, pops, or pain?	Y	N
9. Have you ever had an impact injury to your jaw or face?	Y	N
10. Do you have sinus problems (other than mild seasonal allergy)?	Y	N
11. Do you floss? (If not, should we avoid nagging you about this? Y N)	Y	N

Medical History

- **Brain and nervous system**

1. Seizures or Epilepsy	Y	N
2. Severe headaches	Y	N
3. History of stroke or aneurysm; paralysis?	Y	N
4. Fainting or dizzy spells	Y	N
5. Antidepressants or psychiatric medications _____	Y	N

- **Heart, blood, circulation**

1. Heart attack or heart disease	Y	N
2. Chest pain, angina	Y	N
3. Arrhythmia or Pacemaker	Y	N
4. Heart murmur or Rheumatic Fever	Y	N
5. Artificial heart valve	Y	N
6. Other heart surgery (Bypass, septal defect repair, transplant)	Y	N
7. Congestive Heart Failure or swollen fingers/ankles	Y	N
8. High or low blood pressure. Recent BP _____	Y	N
9. Leukemia, Hemophilia, Anemia	Y	N
10. History of Blood Transfusion (dates) _____	Y	N
11. HIV, CMV, EBV, or chronic fatigue syndrome	Y	N
12. Autoimmune disease or medications _____	Y	N

I certify that I have read and understand both pages of this health history, and to the best of my knowledge all answers are correct. If I have changes to my medications or health, I will inform the doctor at the next appointment without fail.

_____

Date Signature of person completing form Relationship to patient

- **Digestive tract, kidneys**

1. Ulcers ……..... Y N
2. Colitis, diverticulitis, or chronic diarrhea ……..... Y N
3. Hepatitis--A, B, C ……..... Y N
4. Cirrhosis or Other liver disease ……..... Y N
5. Kidney disease or transplant ……..... Y N
6. Chronic bladder infections ……..... Y N

- **Lungs**

1. Asthma ……..... Y N
2. Severe hay fever or sinusitis ……..... Y N
3. Tuberculosis (TB) ……..... Y N
4. Emphysema ……..... Y N
5. Persistent cough ……..... Y N
6. Shortness of breath ……..... Y N
7. Chronic Bronchitis ……..... Y N

- **Eyes, Ears, Throat, Other**

1. Glaucoma? Taking medication for it? _____ Y N
2. Hearing loss, tinnitus (ringing) Y N
3. Chronic sore throats, or swollen lymph glands in your throat? Y N
4. Diabetes? Do you take insulin or other medication for it? Y N
5. Thyroid disease? Taking Thyroid medications? _____ Y N

- **Clotting system**

1. When you cut yourself, does it bleed excessively? Y N
2. Have you ever had a bleeding problem after surgery? Y N
3. Are you taking any anti-coagulation medications? _____ Y N
4. Have you taken aspirin within the past week? _____ Y N

- **Bone and joints**

1. Arthritis? Medications for it? _____ Y N
2. Artificial joints? Other joint surgery? _____ Y N
3. Have you taken Cortisone (steroid) within the past two years? _____ Y N

- **Oral Habits**

1. Are you a smoker? What and how often? _____ Y N
2. Do you chew tobacco or use snuff? Y N
3. Do you use alcohol (more than one drink/day)? Y N
4. Do you use recreational drugs? Y N
5. Do you have a history of alcohol abuse or drug addiction? Y N

- **Allergies (circle any that apply)**

1. Penicillin
2. Sulfa drugs or other antibiotics
3. Aspirin, Acetaminophen, or Ibuprofen
4. Codeine, Demerol, or other narcotics
5. Latex or rubber gloves
6. Chemicals (contact / inhaled) or Costume Jewelry (nickel)

- Women: Are you pregnant, breast feeding, or using birth control meds (circle)?

- Current and recent prescription medications

- Current / recent over-the-counter medications

- Hospitalizations: