HEALTH HISTORY FORM

PATIENT NAME: _____ TODAY'S DATE: _____

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY

HOW LONG SINCE you have seen a Dentist?:_____Last COMPLETE Dental Exam Date:_____
Name of Previous Dentist:_____City:_____State:_____
Last FULL MOUTH X-RAYS Date:_____ (16 small films or Panoramic)

Are you having PROBLEMS now? Yes No What?:_____

Is your present dental health POOR?	Yes	No	Do you wear DENTURES? (Partial or Full)	Yes	No
Are you UNHAPPY with your dentures?	Yes	No	Would you like to know more about PERMANENT REPLACEMENTS?	Yes	No
Are you APPREHENSIVE about dental treatment?	Yes	No	Have you had any PERIODONTAL (GUM) treatments?	Yes	No
Do your gums BLEED, or feel TENDER or IRRITATED?	Yes	No	Are your teeth SENSITIVE to hot, cold, sweets, pressure? (Circle)		
Are you UNHAPPY with the APPEARANCE of your teeth?	Yes	No	Are you aware of GRINDING or CLENCHING your teeth?	Yes	No
Do you have HEADACHES, EARACHES, or NECK PAIN?	Yes	No	Have you worn BRACES on your teeth? (ORTHODONTICS)	Yes	No
Do you have DISCOLORED teeth that bother you?	Yes	No	Would you like your smile to LOOK BETTER or DIFFERENT?	Yes	No
Do you REGULARLY use DENTAL FLOSS?	Yes	No			

How do you feel about your teeth? _____

Please RANK in the order in which they would KEEP YOU FROM having dental treatment:
FEAR of pain #_____ LACK of concern #_____ COST of treatment #_____ MISSING work time #_____

MEDICAL HISTORY

Do you have any CURRENT HEALTH PROBLEMS? Yes No Are you under a PHYSICIANS CARE now? Yes No
For What?:_____
What MEDICATIONS are you currently taking?:_____
Are you Pregnant? Yes No Do you SMOKE? Yes No

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE:

Heart Disease or Attack	A.I.D.S/A.R.C/HIV Pos.	Bruise Easily	Angina Pectoris
Hepatitis A (Infectious)	Emphysema	High Blood Pressure	Hepatitis B (serum)
Tuberculosis (TB)	Heart Murmur	Liver Disease	Asthma
Rheumatic Fever	Blood Transfusion	Hay Fever	Congenital Heart Lesions
Drug Addition	Sinus Trouble	Mitral Valve Prolapse	Hemophilia (Bleeding Problems)
Allergies or Hives	Artificial Heart Valve	Fever Blisters	Diabetes
Heart Pacemaker	Epilepsy or Seizures	Thyroid Disease	Heart Surgery
Nervousness	Radiation Treatment	Psychiatric Treatment	Artificial Joints (Hip, Knee)
Arthritis	Anemia	Glaucoma	Cortisone Medicine
Stroke	Pain in Jaw Joints	Kidney Trouble	Chemotherapy (Cancer, Leukemia)
Venereal Disease	Alcoholism	Ulcers	Venereal Disease (Syphilis,Gonorrhea,
Cosmetic Surgery	Osteoporosis		ect.)

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin Local Anesthetic Erythromycin Nitrous Oxide Codeine Penicillin

Are you aware of being allergic to any other medications or substances? Yes No
If yes, please list:_____
Is there any other Medical or Dental Information that you feel I should know about you? Yes No If yes, please explain:
_____

FAMILY PHYSICIAN_____PHONE NUMBER_____

PATIENT Signature (Parent if Child):_____Date_____

REVIEWED BY DENTIST: (SIGNATURE):_____Date_____