HEALTH HISTORY

Name _____ Significant Other _____
LAST FIRST MIDDLE INITIAL

Address _____
CITY STATE ZIP

Home Phone _____ Business Phone _____ Cell Phone _____

Date of Birth _____

Gender _____ Single ❑ Married ❑

Social Security Number _____ Dental Insurance _____

Employer _____ Occupation _____

Email Address _____

Emergency Contact _____ Phone Number _____

Whom may we thank for referring to us? _____

MEDICAL HEALTH

Name and address of Physician _____

Date of last wellness exam _____

Have you been hospitalized during the last year? ____ For what? _____

List any major surgeries: _____

Females: Are you taking hormones or birth control? ____ Pregnant or nursing? _____

Have you had cankers or cold sores on your lips, tongue or gums? _____

Please list all prescription medications you are currently taking, or have taken, in the last year _____

_____

_____

Please list any over the counter medications/ vitamins/ supplements you are currently taking _____

_____

_____

Are you taking bisphosphonates such as Boniva, Prolia or Fosamax? _____

Are you taking blood thinners such as Coumadin, Xarelto or Aspirin? _____

Are you allergic to: Penicillin? ____Codeine? ____ Local anesthetics? ____ Latex? ____ Other? _____

Do you use tobacco, medical cannabis or electronic cigarettes? (please circle any that may apply)

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

	yes	no
Abnormal blood pressure	❑	❑
AIDS/ HIV	❑	❑
Allergies (seasonal/ hay fever)	❑	❑
Anemia	❑	❑
Angina	❑	❑
Arthritis	❑	❑
Artificial heart valves	❑	❑
Artificial joints	❑	❑
Asthma	❑	❑
Blood transfusions	❑	❑
Cancer	❑	❑
Chemotherapy	❑	❑
Congenital heart lesions	❑	❑
COPD	❑	❑
CPAP or BiPAP Device	❑	❑
Diabetes	❑	❑
Drug or substance dependency	❑	❑
Epilepsy/ Seizures	❑	❑
Fainting	❑	❑
Glaucoma	❑	❑
Heart disease	❑	❑

	yes	no
Heart murmur/ mitral valve prolapse	❑	❑
Hepatitis	❑	❑
Inhaler or oral steroids	❑	❑
Kidney disease	❑	❑
Liver disease and/or jaundice	❑	❑
Mental health care	❑	❑
Organ transplant	❑	❑
Pacemaker	❑	❑
Prolonged bleeding	❑	❑
Prolonged cough	❑	❑
Radiation Therapy	❑	❑
Rheumatic fever	❑	❑
Sexually transmitted disease	❑	❑
Shingles and or the shingles/vaccine	❑	❑
Shunt/stent	❑	❑
Sickle cell anemia	❑	❑
Stroke	❑	❑
Thyroid disease	❑	❑
Tuberculosis	❑	❑
Ulcers	❑	❑

Have you ever been told to PREMEDICATE prior to a dental visit? YES ❑ NO ❑

Why?_____

DENTAL HEALTH HISTORY

When was your last dental visit?_____

How often did you see your dentist?_____

Are you having any dental problems that require immediate attention?_____

Do any of the following cause tooth discomfort: Hot? ____ Cold? ____ Sweets? ____ Chewing? ____

How often do you brush your teeth daily?_____Floss?_____Water Pik?_____

Do your gums bleed while brushing or flossing?_____

Do your gums ever feel tender or swollen? _____

Have you had periodontal treatment? ____ Mucogingival surgery? ____ Soft tissue graft? ____ When? ____

Do you clench or grind your teeth?_____

Do your jaws ever feel tired or ache? ____ Click or pop? ____ Lock? ____

Do you chew on both sides of your mouth comfortably?_____

Do you have frequent headaches? ____ Earaches? ____

Have you ever had orthodontic treatment (braces) or aligner trays?_____

Do you lose or break fillings?_____

Do you have any loose teeth?_____

Cracked or broken teeth?_____

Do you have any noticeable wear on your teeth?_____

Do you have any missing teeth? Have they been replaced?_____

If so, how? Fixed bridge____ Removable partial____ Full denture ____ Dental Implant ____

Are you comfortable with the replacement? ____ Please describe_____

Have you ever had an unpleasant dental experience?_____

_____

_____

_____ _____

SIGNATURE DATE