## HEALTH HISTORY

Name_____ Date of Birth _____Male____Female_____

Are you currently under a physicians care? ____Yes ____No. Details:_____

Physician's Name_____Phone_____

Physician's Address_____

**Allergic to any medication**? ____Yes ___No. **If yes please list & describe type of reaction.**

Medication _____ Reaction_____

Latex Allergy? ____ Yes _____ No. Please describe reaction_____

Previous Surgeries? __Yes __No. Please list type of surgery and date performed.

_____

_____

List All Current Medications (Prescription, Over the Counter, Herbal Supplements)

| **Medication** | **Dosage** | **Frequency** |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

**Past & Current Medical Conditions (Please mark all that apply)**

__Heart Disease
__Heart Failure/Attack
__Rheumatic Fever
__Heart Murmur
__Mitral Valve Prolapse
__Heart Surgery
__Congenital Heart Problem
__Artificial Heart Valve/Stent
__Pacemaker
__Implanted Defibrillator
__High Blood Pressure
__Stroke
__Diabetes ___A1C Level
__Family History of Diabetes
__Artificial Joints
__Organ Transplant
__High Cholesterol

__Bleeding Problem
__Hemophilia
__Blood Transfusion
__Anemia
__Leukemia
__Fainting/dizzy spells
__Nervousness
__Lung Disease
__Asthma
__Emphysema
__Sleep Apnea
__Tuberculosis
__Cancer
__Radiation Therapy
__Chemotherapy
__Kidney Disease

__Eating Disorder
__Acid Reflux/GERD
__Stomach Ulcer
__Liver Disease
__Hepatitis A, B, C
__HIV Positive
__Autoimmune Disease
__Thyroid Disease
__Glaucoma
__Sjorens Syndrome
__Fibromyalgia
__Arthritis
__Depression
__Psychiatric Disorder
__Epilepsy
__Cerebral Palsy
__Venereal Disease

**If you have answered yes to any of the above please explain._____**

_____

_____

_____

Do you smoke or use tobacco? _____ Do you drink sodas? _____ How many per day? _____

**Women:**
__Pregnant (what trimester)? _____
__Nursing
__Using an Oral Contraceptive

**SIGNATURE_____DATE_____**

**DENTAL HEALTH HISTORY**

***Your initial clinical exam combined with your dental and medical history is important for us to recommend the best overall treatment approach for you. Oral health is directly related to your overall health and specific medical conditions are related to your mouth. Please mention everything about your health.***

What is the reason for your dental visit today? _____

How did you hear about our practice? _____

On a scale from 1-10 with 10 being the highest, how important our your teeth?_____

When was your last dental visit? _____ Last dental cleaning? _____

How frequently did you have your dental cleaning? _____

Who was your previous dentist? _____Phone_____

Were you told you have gum disease? _____ Were you treated?_____

Have you ever had orthodontic treatment? _____ Do you wear orthodontic retainers? _____

Name of Orthodontist _____Phone _____

Have you had oral surgery? _____ Wisdom teeth removed? _____When?_____

Have you had dental implants placed? _____ How long ago?_____

Do you or have you been told you grind/clench your teeth? _____

Do you have pain, popping or clicking in your jaws? _____

Do you wear or have an occlusal appliance? _____

Do your wear dentures or partial dentures ? _____ How long? _____

Are any of your teeth sensitive to hot, cold or sweets? _____

Is your mouth frequently dry? _____ Are you noticing any swelling or lumps?_____

Do you have any loose teeth or trouble chewing? _____

Do you have any food that catches between your teeth?_____

Do you frequently get cold sores or oral blisters?_____

Do you notice bad breathe or tastes?_____ Do you gag easily?_____

Are you interested in whitening your teeth?_____ Enhancing your smile? _____

Are you interested in cosmetic dental treatment or dental veneers? _____

Have you ever experienced a complication following dental treatment? _____

**Signature_____Date_____**