HEALTH HISTORY

NAME:_____

A. DENTAL HEALTH

Has your dental care been?

Regular □No□Yes
Intermittent □No□Yes

Do you feel apprehensive about dentistry? □No□Yes

Have you ever experienced?

Bleeding gums □No□Yes
Pus □No□Yes
Swollen gums □No□Yes
Loose teeth □No□Yes
Sore gums □No□Yes
Spacing of teeth □No□Yes
Receding gums □No□Yes
Drifting of teeth □No□Yes
Foul odor □No□Yes
Bad breath or taste □No□Yes

Is there sensitivity in your teeth with?

Hot □No□Yes
Cold □No□Yes
Sweets □No□Yes
Biting □No□Yes
Tooth brushing □No□Yes
Pressure □No□Yes

Do you suffer from pain in?

Face □No□Yes
Neck □No□Yes
Jaw □No□Yes
TMJ □No□Yes

Have you had any unfavorable reaction from local anesthetics? □No□Yes

Please explain:
Dr. comments:

B. GENERAL HEALTH

Current weight:_____
Height:_____
Age:_____
Have you recently lost weight? □No□Yes

Last physical:___/___/___
Physician:_____
Phone:(____)_____

Emergency contact:_____
Phone:(____)_____

Any health problems in the last year? □No□Yes
Any hospitalization during the past two years? □No□Yes
Dr. comments:

1. HEART & LUNGS

Heart trouble □No□Yes
Heart Murmur □No□Yes
Damaged valves □No□Yes
MVP □No□Yes
Artificial valves □No□Yes
Rheumatic fever □No□Yes
Coronary insufficiency □No□Yes
Myocardial infarction. □No□Yes
Year:
Bypass heart surgery. □No□Yes
Year:
Heart pacemaker □No□Yes
Heart transplant □No□Yes
Year:
Chest pain □No□Yes
Lung trouble □No□Yes
Asthma □No□Yes
Tuberculosis □No□Yes
Year:
Unexplained cough □No□Yes
Emphysema □No□Yes
Dr. comments:

2. NEUROLOGY & PSYCHIATRICS

Convulsions □No□Yes
Epilepsy □No□Yes
Fainting □No□Yes
Psychiatric treatment □No□Yes
Year
Suicidal tendency □No□Yes
Stroke □No□Yes
Year:
TIA □No□Yes
Parkinson □No□Yes
ALS □No□Yes
Other:
Dr. comments:

3. DIGESTIVE SYSTEM

Stomach ulcer □No□Yes
Year:
Colitis □No□Yes
Year:
Dr. comments:

4. JOINTS

Arthritis □No□Yes
Artificial joint □No□Yes
Year:
Dr. comments:

5. BLOOD & BLOOD PRESSURE

Arteriosclerosis □No□Yes
Hemophilia □No□Yes
Blood transfusion □No□Yes
Year:
Blood trouble □No□Yes
Anemia □No□Yes
Sickle cell anemia □No□Yes
Bleed easily □No□Yes
Bruise easily □No□Yes
High blood pressure □No□Yes
List blood pressure medications:

_____
_____
_____
Dr. comments:

6. KIDNEY

Kidney trouble □No□Yes
Year:
Dialysis □No□Yes
Year:
Kidney transplant □No□Yes
Year:
Dr. comments:

7. ADDICTIONS

Drug addiction □No□Yes
Year:
Alcoholism □No□Yes
Year:
Smoking □No□Yes
(cigarettes/day:)

8. CANCER

Leukemia □No□Yes
Year:
Malignant tumor □No□Yes
Year:
Tumor location:

_____
Radiation therapy □No□Yes
Chemotherapy □No□Yes
Dr. comments:

9. LIVER

Liver insufficiency □No□Yes
Jaundice □No□Yes
Year:
Hepatitis A, B or C □No□Yes
Year:
Transplant □No□Yes
Year:
Dr. comments:

10. ENDOCRINE

Controlled Diabetes □No□Yes
Uncontrolled Diabetes □No□Yes
Thyroid trouble □No□Yes
Parathyroid trouble □No□Yes
Dr. comments:

11. EYES

Glaucoma □No□Yes
Contact lenses □No□Yes
Dr. comments:

12. INFECTIOUS DISEASES

Tuberculosis □No□Yes
Hepatitis A, B or C □No□Yes
AIDS □No□Yes
Year:
HIV □No□Yes
Year:
Dr. comments:

13. FOR WOMEN ONLY

Anticipated pregnancy □No□Yes
Pregnancy □No□Yes
Months of gestation: _____
Nursing □No□Yes

14. ALLERGIES

Hay fever □No□Yes
Hives □No□Yes
Skin rash □No□Yes
Sinus trouble □No□Yes
Penicillin □No□Yes
Amoxicillin □No□Yes
Erythromycin □No□Yes
Keflex □No□Yes
Tetracycline □No□Yes
Clindamycin □No□Yes
Aspirin □No□Yes
Tylenol □No□Yes
Codeine □No□Yes
Xylocaine □No□Yes
Lidocaine □No□Yes
Carbocaine □No□Yes
Marcaine □No□Yes
Septocaine □No□Yes
Latex □No□Yes
Peanuts □No□Yes
*Other*_____
Dr. comments:

16. I AM CURRENTLY TAKING

Antibiotics:

Blood modifiers:

Anti-seizure:

Asthma medications :

Psycho-therapeutics:

Anti-inflammatory:

Anti-allergy:

Anti-Diabetics:

Heart Medications:

Hormones:

Anti-rejection drugs:

Bisphosphonates: *FOSAMAX, DIDRONEL, RECLAST, ZOMETA, ATELVIA, BONIVA, ACLASTA, ACTONEL, AREDIA, BINOSTO, SKELID.*
Since:

Others:

Dr. comments:

Date:____/____/_____

Patient signature:_____

Dr. Signature:_____