PATIENT NAME ______________________ REG# ______________

Date of birth ______________

HEALTH HISTORY FORM

Please CIRCLE the appropriate response next to each question below: Yes (Y), No (N), Don't Know (?)

MEDICAL HISTORY

Do you have or have you had any of the following:

1. *Breathing problems?*

a. Asthma	Y	N	?
b. Emphysema	Y	N	?
c. Bronchitis	Y	N	?
d. Tuberculosis	Y	N	?
e. Shortness of breath	Y	N	?
f. Other breathing problems	Y	N	?

Explain: ______________

2. *Heart or circulation problems?*

a. High blood pressure	Y	N	?
b. Heart attack	Y	N	?
c. Angina or chest pain	Y	N	?
d. Irregular heart beat	Y	N	?
e. Rheumatic fever	Y	N	?
f. Heart murmur	Y	N	?
g. Mitral valve prolapse	Y	N	?
h. Damage to heart valves	Y	N	?
i. Heart valve replacement	Y	N	?
j. Pacemaker/other cardiac device	Y	N	?
k. Congestive heart failure	Y	N	?
l. Swollen ankles	Y	N	?
m. Other heart or circulation problems	Y	N	?

Explain: ______________

3. *Kidney or urinary problems?*

a. Kidney disease	Y	N	?
b. Dialysis	Y	N	?
c. Frequent urination	Y	N	?
d. Other kidney problems	Y	N	?

Explain: ______________

4. *Nervous system problems?*

a. Stroke or transitory ischemic attack	Y	N	?
b. Fainting spells	Y	N	?
c. Convulsions, seizures or epilepsy	Y	N	?
d. Other nervous system problems	Y	N	?

Explain: ______________

5. *Head and neck problems?*

a. Nose or sinus problems	Y	N	?
b. Swollen glands	Y	N	?
c. Oral cancer	Y	N	?
d. Impairment of hearing, sight or speech	Y	N	?
e. Frequent or severe headaches	Y	N	?
f. Other head and neck problems	Y	N	?

Explain: ______________

6. *Hormone or gland problems?*

a. Thyroid disease (hypothyroidism, hyperthyroidism)	Y	N	?
b. Diabetes	Y	N	?
c. Adrenal or pancreatic disease	Y	N	?
d. Any other hormone/gland disease	Y	N	?

Explain: ______________

7. *Muscle, bone or skin problems?*

a. Arthritis	Y	N	?
b. Osteoporosis	Y	N	?
c. Artificial joint placement	Y	N	?
d. Hives or skin rash	Y	N	?
e. Skin cancer	Y	N	?
f. Back problems	Y	N	?
g. Other muscle, bone or skin disease	Y	N	?

Explain: ______________

8. *Stomach, liver or intestinal problems?*

a. Liver disease	Y	N	?
b. Hepatitis	Y	N	?
c. Acid reflux (GERD)	Y	N	?
d. Ulcers	Y	N	?
e. Other stomach, intestinal or liver problems	Y	N	?

Explain: ______________

EXAMINER'S COMMENTS ______________________________

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9. Allergic reactions or other problems?

a. Seasonal allergies Y N ?

b. Allergy, reaction or intolerance to:

Penicillin	Y	N	?
Erythromycin	Y	N	?
Codeine	Y	N	?
Latex	Y	N	?
Local anesthetics	Y	N	?
Foods/flavoring	Y	N	?
Other substances	Y	N	?

Explain: ______________________________

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10. Blood or immune system problems?

a. Cancer of any type	Y	N	?
b. Organ or bone marrow transplant	Y	N	?
c. Lupus	Y	N	?
d. Multiple sclerosis	Y	N	?
e. Anemia	Y	N	?
f. Hemophilia	Y	N	?
g. AIDS/HIV	Y	N	?
h. Frequent nosebleeds, increased bruising or bleeding	Y	N	?
i. Are you taking any blood thinners?	Y	N	?
j. Have you had chemotherapy or radiation treatment?	Y	N	?
k. Other problems with the blood or immune system?	Y	N	?

Explain: ______________________________

11. What medications or other substances are you taking or have you taken in the past 2 months?

a. Please list all prescription and non-prescription drugs including aspirin, birth control pills, herbal medications or other supplements. Write "none" if you are not taking any medications or other substances.

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b. Have you ever taken the drugs Fenfluramine(Fen-phen), Pondimin, or Dexfenfluramine(Redux)?	Y	N	?
c. Have you taken or are you taking drugs to control bone loss? (ie. Fosamax®)	Y	N	?

12. Personal History

a. Have you ever been hospitalized, had major surgery or been seriously hurt? Y N ?

If yes, what type and when ______________________________

b. Have you had or do you have any sexually transmitted diseases (syphilis, gonorrhea, herpes, etc.)?	Y	N	?
c. Do you need any special accommodations for dental treatment?	Y	N	?
d. Are you pregnant?	Y	N	?
e. Have you ever used tobacco products?	Y	N	?
f. Are you currently using tobacco products?	Y	N	?

What type and how often ______________________________

g. How many alcohol containing drinks do you consume a week? ____________

h. Do you use or have you used recreational drugs?	Y	N	?
i. Have you ever had a problem with alcohol and/or drugs?	Y	N	?
j. Do you have mental health problems?	Y	N	?

k. When was your last visit to a physician (medical doctor)? ______________________________

l. Do you have a physician (medical doctor)? Y N ?

If yes, please provide the Name, Address and Telephone ______________________________

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EXAMINER'S COMMENTS ______________________________

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DENTAL HISTORY

1. What is the reason for your dental visit? ______________________________

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		Y	N	?
2.	Have you ever had any problems following dental treatment?	Y	N	?
	If yes, please explain ______________________________			
3.	Have you ever had a bad or unusual reaction to local anesthetic?	Y	N	?
4.	Have you ever had a severe injury to your face, teeth or jaws?	Y	N	?
5.	Have you ever had surgery in your mouth or on your lips?	Y	N	?
6.	Have you ever had periodontal treatment to your gums?	Y	N	?
7.	Have you ever had orthodontic treatment to straighten your teeth?	Y	N	?
8.	Have you ever had extraction (pulling) of any teeth?	Y	N	?
9.	Have you ever had endodontics (root canals) on any teeth?	Y	N	?
10.	Have you had any missing teeth replaced by a removable denture, fixed bridge or an implant?	Y	N	?
11.	Have you ever worn a bitesplint/nightguard?	Y	N	?
12.	Have you had a recent toothache?	Y	N	?
13.	Are your teeth sensitive to hot, cold or pressure?	Y	N	?
14.	Do you have bleeding gums?	Y	N	?
15.	Do you have trouble chewing?	Y	N	?
16.	Do you clench or grind your teeth?	Y	N	?
17.	Do you have difficulty opening your mouth as wide as you would like?	Y	N	?
18.	Do your jaw joints or muscles hurt?	Y	N	?
19.	Does your jaw click, pop or lock when you chew?	Y	N	?
20.	Do you experience a dry mouth?	Y	N	?
21.	Do you have sores in or around your mouth?	Y	N	?
22.	Please circle the amount of sugar in your diet.	small	moderate	high

23. When was the last time your teeth were cleaned at a dental office? ______________________________

24. How often do you brush? ______________________________

25. How often do you use dental floss? ______________________________

26. Are you satisfied with the appearance of your teeth? Y N ?

If No, Why not? ______________________________

27. Do you have any questions, concerns, or additional information you would like us to know before we treat you? Y N ?

If Yes, please specify? ______________________________

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28. How do you feel about going to the dentist (please circle) Scared Apprehensive No problem

EXAMINER'S COMMENTS ______________________________

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