DENTAL HEALTH HISTORY

Today's Date_____

Patient Name_____Birthdate_____

Address_____

Cell Number_____ E-Mail_____

Reason for Today's visit_____

Check (√) if you have had problems with any of the following:

☐ Bad breath	☐ Grinding teeth	☐ Sensitivity to hot
☐ Bleeding gums	☐ Loose teeth	☐ Sensitivity to cold
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity to sweets
☐ Food collection between teeth	☐ Pain in mouth	☐ Sores or growths in mouth

How often do you brush? _____How often do you floss? _____

Physicians Name_____Physicians #_____

Have you ever had any serious illness or operations? If yes, when & describe_____

_____

(Women) Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No

Check (√) if you have or have had problems with any of the following:

☐ Anemia	☐ Cortisone Treatments	☐ Hepatitis	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cough, Persistent	☐ High Blood Pressure	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Cough up Blood	☐ HIV/AIDS	☐ Skin Rash
☐ Artificial Joints	☐ Diabetes	☐ Jaw Pain	☐ Stroke
☐ Asthma	☐ Epilepsy	☐ Kidney Disease	☐ Swelling
☐ Back Problems	☐ Fainting	☐ Liver Disease	☐ Thyroid Problems
☐ Blood Disease	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tobacco Habit
☐ Cancer	☐ Headaches	☐ Pacemaker	☐ Tonsilitis
☐ Chemical Dependency	☐ Heart Murmur	☐ Radiation Treatment	☐ Tuberculosis
☐ Chemotherapy	☐ Heart Problems	☐ Respiratory Disease	☐ Ulcer
☐ Circulatory Problems	☐ Hemophilia	☐ Rheumatic Fever	☐ Venereal Disease

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List medications you are taking_____

_____

Pharmacy Name and #_____

Check (√) if you have or have had an allergic reaction with any of the following:

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Metals	☐Other-
☐ Sulfa	☐ Other Antibiotics	☐ Sleeping Pills	☐ Latex	Describe_____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature _____ Date_____