HEALTH INFORMATION CHART #_____

NAME_____ Age_____ Date of Birth_____
Last name First Name

DENTAL HISTORY

Please circle the correct response (Yes) No

- Are there other conditions of which we should be aware? Yes_____ No_____ If yes, please Explain_____
- Why are you here today? Check Up: _____ Cleaning: _____ Toothache: _____ Chief Complain: _____
- When did you last visit a dentist? _____ what treatment was performed? _____
- Did you have a cleaning? Yes No Former Dentist _____
- Were dental X-Rays taken? Yes No _____
- Have you ever had prolonged bleeding after an extraction? Yes No
- Have you had any problems with past dental treatment? Yes No
- Have you had problems with your ears? Yes No
- Have you ever been diagnosed or treated for TMD? Yes No
- Do your gums bleed easily? Yes No
- Do you feel you have bad breath? Yes No
- Are your teeth sensitive to hot or cold things? Yes No
- Would you like to have your teeth whiter? Yes No
- Would you like to have any cosmetic changes done on your teeth? Yes No
- Have you ever had complications with local anesthetic? Yes No

MEDICAL HISTORY

- Are you under a Doctor's care at this time? Yes No
-
- Dr's Name: _____ Phone #: _____
-
- Are you allergic to PENICILLIN, CODEINE, LOCAL ANESTHETICS, TRANQUILIZERS or any other drugs or medicine?

  If yes, please explain? _____
-
- Are you taking any medications at this time, including birth control? Yes No If yes, please specify: _____
-
- _____
-
- (Woman) Are you pregnant at this time? Yes No If yes, please specify how many months? _____
-
- Are there any other health problems of which we should be advised? Please specify? _____

Do you have or have had any of the following?

HEART PROBLEMS

Y / N Artificial valve
Y / N Chest pain
Y / N Circulatory Problems
Y / N Congenital heart defect
Y / N Heart Attack
Y / N Heart Murmur
Y / N H / L Blood Pressure
Y / N Mitral Valve Prolaps
Y / N Pacemaker

Y / N AIDS / HIV
Y / N Asthma
Y / N Cancer
Y / N Chemotherapy
Y / N Diabetes
Y / N Drug Addiction
Y / N Emphysema
Y / N Epilepsy / Seizures
Y / N Excessive Bleeding
Y / N Fainting

OTHER ILLNESSES / TREATMENTS

Y / N Artificial Joints / Limbs
Y / N Herpes
Y / N Hepatitis
Y / N Kidney Disease / Dialysis
Y / N Latex Allergy
Y / N Liver Problems
Y / N Nervous / Anxious
Y / N Osteoporosis
Y / N Phen Phen
Y / N Psychiatric care

Y / N Radiation Therapy
Y / N Respiratory Problems
Y / N Rheumatic / Scarlet Fever
Y / N Sinus Problems
Y/ N Shunts
Y / N Stents
Y/ N Stroke
Y / N TMD or TMJ
Y / N Tuberculosis

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/ or Medication I further certify that I consent to the performing of x-rays and oral examinations.

Patient's Signature: _____ Date: _____
(Guardian Signature if patient is a minor)

RECALL REVIEW: Doctor's Signature: _____

Patient's Signature: _____ Doctor's Signature: _____

Patient's Signature: _____ Doctor's Signature: _____