DATE__________________

PATIENT INFORMATION AND HEALTH HISTORY

PATIENTS NAME____ M□ F□ DATE OF BIRTH________________________

PATIENTS ADDRESS____HOME PHONE__________________________________

CITY,STATE,ZIP____CELL PHONE______________________________

IN CASE OF EMERGENCY, CALL:____________________________RELATIONSHIP___________________PHONE_________________

PHYSICIAN'S NAME_________________________________PHONE_______________________DATE OF LAST VISIT______________

- Are you having any pain or discomfort at this time?.. Yes No
- Do you feel nervous about having dental treatment?.. Yes No
- Have you ever had a bad experience in a dental office?.. Yes No
- Have you taken any medicine or drugs in the past two years?.. Yes No
- List current medications ____
- Are you allergic to (*ie: itching, rash, swelling of hands, feet or eyes)* or made sick by Penicillin, aspirin, codeine, or any other drugs or medication?............................... Yes No

Circle any of the following which you have had or have at present:

Heart Failure	Chronic Cough	Hepatitis A (infectious)	Artificial Joint	Alcohol Abuse
Heart Disease or Attack	Tuberculosis	Hepatitis B (serum)	Anemia	Sickle Cell Disease
Angina Pectoris	Asthma	Liver Disease	Stroke	Cold Sores
High Blood Pressure	Emphysema	Yellow Jaundice	Kidney Trouble	AIDS
Heart Murmur	Sinus Trouble	Blood Transfusion	Ulcers	Glaucoma
Rheumatic Fever	Allergies or Hives	Drug Addiction	Hay Fever	Bruise Easily
Congenital Heart Lesions	Diabetes	Hemophilia	Arthritis	Nervousness
Scarlet Fever	Thyroid Disease	Venereal Disease	Rheumatism	Psychiatric Treatment
Artificial Heart Valve	Latex Allergy	Syphilis, Gonorrhea	HIV Positive	Cortisone medicine
Heart Pacemaker	Radiation Treatment	Genital Herpes	Epilepsy / Seizures	Cancer/Leukemia
Heart Surgery	Chemotherapy	Fainting /Dizzy Spells		

- Do you experience migraine or frequent headaches?... Yes No
- Do you smoke cigarettes, cigars, pipe?............... Yes No If yes, how much?______________________
- When you walk upstairs or take a walk do you ever stop because of pain in your chest, shortness of breath, or because you are very tired?... Yes No
- Do your ankles swell during the day?.. Yes No
- Do you use more than two pillows to sleep?... Yes No
- Have you lost or gained more than 10 pounds in the past year?.................................... Yes No
- Do you ever wake up from sleep short of breath?.. Yes No
- Are you on a doctor prescribed diet? .... Yes No
- Do you have any disease, condition or problem not listed? Describe___________________ Yes No

WOMEN: Are you pregnant now? Yes No
Are you practicing birth control? Yes No
Do you anticipate becoming pregnant? Yes No

(Staff Use Only)

B.P_________________________

Pulse:_______________________

Comments:

Date of last dental exam______________________ Any previous major dental treatment? □NO □YES

Do you have any problems that require immediate attention?____

Do you have any of the following? (Please indicate with a √)

□Teeth sensitive to cold, heat, sweets, pressure	□Frequent blisters on lips or mouth	□Swelling or lumps in mouth	□Mouth Breathing
□Clenching or Grinding	□Food impaction	□Complications from extractions	
□Periodontal Treatment	□Orthodontic Treatment	□Bleeding gums? How long?_______	
□Clicking or popping in ear joint	□Snoring	□Pain around ear or in jaw joint	
□Unusual sounds in ear upon opening mouth	□Oral Habits (cheek/fingernail biting)	□Burning of tongue	

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have a change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

____ ____________________

Signature of Patient, Parent or Guardian **Date**