Patient Name: (PRINT)	Sex:	Birthdate:

HEALTH HISTORY:

Health problems or medications that you may be taking could have an important interrelationship with the dentistry that you are receiving. Your dentist is legally obligated to ask you the following questions, thank you for answering them.

Physician: _____ **Phone Number:** _____

Are you in good health: _____ **If no explain:** _____

Are you currently on a blood thinner or Aspirin regimen: _____

Have you been hospitalized in the last two years? _____

Are you taking any medications? (If yes, please list) _____

Do you NOW HAVE, or HAVE YOU EVER HAD any of the following? (Please check (X) box for EVERY question)

		YES	NO
1.	Heart Disease / Defect	☐	☐
2.	High Blood Pressure	☐	☐
3.	Infective Endocarditas	☐	☐
4.	Diabetes	☐	☐
5.	Stroke	☐	☐
6.	Epilepsy or Seizures	☐	☐
7.	Fainting or Dizzy Spells	☐	☐
8.	Major Surgery last 5 years	☐	☐
9.	Tumor History / Cancer	☐	☐
10.	AIDS, ARC or HIV+	☐	☐
11.	Radiation Treatment	☐	☐
12.	Liver Disease / Hepatitis	☐	☐
13.	Kidney Disease	☐	☐
14.	Cold sores, Fever Blisters	☐	☐
15.	Nervous at the Dentist	☐	☐
16.	Asthma	☐	☐
17.	Recreational Drugs	☐	☐
18.	Smoke or chew tobacco	☐	☐
19.	Tuberculosis	☐	☐
20.	Are you pregnant or trying	☐	☐
21.	Sinus trouble	☐	☐
22.	Breathing problems / Emphysema	☐	☐
23.	Unusual facial pain	☐	☐
24.	Head or neck injury	☐	☐
25.	Bisphosphonate therapy	☐	☐
26.	Antiplatelet therapy	☐	☐
27.	Sensitivity to latex or balloons	☐	☐
28.	Allergy to:	☐	☐
	(a) Penicillin or Amoxicillin	☐	☐
	(b) Other Antibiotics	☐	☐
	(c) Aspirin	☐	☐
	(d) Other	☐	☐
29.	Sleep Apnea or Snoring	☐	☐

If you answered yes to #29, please fill out the Sleep Health Questionnaire on the back.

30. Artificial Joints ---------- Yes No

If yes please explain: _____

REMARKS:

DENTAL HISTORY:

Previous Dentist: _____ **City:** _____ **State:** _____

Do you have any present dental concerns? _____

When was your last full mouth x-ray taken? _____ **Do you require a PRE-MED before receiving dental care?** _____

When was your last cleaning? _____ **Were you pleased with the results?** _____

Please check (√) any of the following that you currently have or have had in the past:

__ Gum disease / gingivitis?
__ Periodontal disease / gum surgery?
__ Instruction on oral hygiene?
__ History of clenching / grinding teeth?
__ Bad reaction to anesthetic / nitrous oxide?
__ Loosened adult teeth?
__ Difficulty getting numb?
__ Popping, clicking, or pain in TMJ?
__ Sensitivity to hot, cold, or sweets?
__ TMJ (jaw joint) problems/treatment?
__ Difficulty in opening mouth wide?
__ Difficulty chewing?
__ Unfavorable experience in a previous dental office?

Do you want to keep your remaining teeth? _____ **Would you like to speak to the doctor privately?** _____

Is there anything that concerns you about the appearance of your teeth or smile? _____

_____

Are you pleased with the color and/or shape of your teeth? _____

What should we know about you to make your visits as comfortable as possible? _____

_____

Whom may we thank for referring you to our office? _____

How would you like to be addressed in our office? (First / Last Name? Nickname?) _____

I hereby certify that the above is correct to the best of my knowledge. (It is the patient's responsibility to notify us if any of this information changes.)

_____ _____

Patient Signature **Date** **Reviewing Doctor** **Date**