

HEALTH HISTORY

NAME	DATE OF BIRTH	AGE	SEX: (CIRCLE) M F
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MEDICAL HISTORY

1. Have you ever had any of the following:

GENERAL	YES	NO	HEART/BLOOD VESSELS	YES	NO
Tire easily, weakness	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Marked weight change	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain/discomfort	<input type="checkbox"/>	<input type="checkbox"/>
Persistent fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack/trouble	<input type="checkbox"/>	<input type="checkbox"/>
SKIN			Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Eruptions (rash/hives)	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of ankles	<input type="checkbox"/>	<input type="checkbox"/>
Changes in skin color	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
EYES			Congenital heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Visual change	<input type="checkbox"/>	<input type="checkbox"/>	Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
EARS			Other_____	<input type="checkbox"/>	<input type="checkbox"/>
Loss of hearing	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD		
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding tendency	<input type="checkbox"/>	<input type="checkbox"/>
Pain in or by ear (s)	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>
NOSE			Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems/allergies	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell disease	<input type="checkbox"/>	<input type="checkbox"/>
THROAT			Other_____	<input type="checkbox"/>	<input type="checkbox"/>
Soreness/hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	BONE/MUSCLES		
RESPIRATORY			Arthritis/rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	DIGESTIVE SYSTEM		
Asthma/hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice (yellow)	<input type="checkbox"/>	<input type="checkbox"/>
Sputum production (phlegm)	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Cough up bloody sputum	<input type="checkbox"/>	<input type="checkbox"/>	URINARY		
Difficulty in breathing while lying down	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE			Increase in frequency of urination at night	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Burning on urination	<input type="checkbox"/>	<input type="checkbox"/>
Family history of Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Urethral discharge	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid condition/goiter	<input type="checkbox"/>	<input type="checkbox"/>	Bloody urine	<input type="checkbox"/>	<input type="checkbox"/>
Other_____	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
NERVOUS SYSTEM			Syphilis	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Other_____	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	OTHER		
Numbness/tingling	<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/fainting	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or growths	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>

MEDICATIONS

2. Are you taking any of the following:

	YES	NO
Antibiotics/sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
Blood thinners	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure medication	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid medicine	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone/steroids	<input type="checkbox"/>	<input type="checkbox"/>
Recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>
Antihistamines/allergy drugs/ cold remedies	<input type="checkbox"/>	<input type="checkbox"/>
Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>
Insulin/other diabetes drugs	<input type="checkbox"/>	<input type="checkbox"/>
Digitalis/other heart drugs	<input type="checkbox"/>	<input type="checkbox"/>
Nitroglycerin	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Birth control medication	<input type="checkbox"/>	<input type="checkbox"/>
Other_____	<input type="checkbox"/>	<input type="checkbox"/>

List name of medication and dosage below:

Name	Dosage
1. _____	
2. _____	
3. _____	
4. _____	
5. _____	
6. _____	
7. _____	
8. _____	
9. _____	
10. _____	

3. Are you ALLERGIC or have ever experienced any reaction to the following?

	YES	NO
Local anesthetics (novocaine)	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates/sedatives/sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin/other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin or codeine	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
Other_____	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL HISTORY (continued)

- | | YES | NO |
|---|--------------------------|--------------------------|
| 4. Are you in good health now?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you under the care of a physician?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, what is the condition being treated? _____ | | |
| 6. Have you ever been hospitalized or had a serious illness? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, explain _____ | | |
| 7. Have you ever had excessive bleeding following an extraction?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| or do cuts take longer to heal now than previously?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. (Women) Are you pregnant? (If so, give due date _____)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you smoke? If yes, how much _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you drink alcohol? (more than 2 drinks per day)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Is there any disease, condition or problem not listed that you think we should know about, or is there any activity your doctor says you cannot do? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please explain: _____ | | |
| 12. Physician's Name _____ Physician's Phone _____ | | |
| Physician's Name _____ Physician's Phone _____ | | |

DENTAL HISTORY

13. Why are you seeking dental treatment? _____
- | | YES | NO | | | | | | |
|---|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|
| 14. Have you ever had any unfavorable reaction from a local anesthetic (Novocaine)?..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | |
| 15. Have you ever had any serious trouble associated with any previous dental treatment?..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | |
| If so, explain _____ | | | | | | | | |
| 16. Does dental treatment make you nervous? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | |
| Slight _____ Moderate _____ Extremely _____ | | | | | | | | |
| 17. Date of last dental visit _____ last cleaning _____ last dental x-ray _____ | | | | | | | | |
| 18. Have you ever been treated for periodontal disease (gum disease, pyorrhea)?..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | |
| If so, when? _____ | | | | | | | | |
| 19. Have you ever had any of the following? | | | | | | | | |
| MOUTH & FACE | YES | NO | TEETH | YES | NO | ORAL HYGIEN | YES | NO |
| Clicking/popping jaw | <input type="checkbox"/> | <input type="checkbox"/> | Loose teeth | <input type="checkbox"/> | <input type="checkbox"/> | Brush | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty closing/opening jaw | <input type="checkbox"/> | <input type="checkbox"/> | Sensitive to hot/cold | <input type="checkbox"/> | <input type="checkbox"/> | How often _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Painful muscles of face, jaw, temple | <input type="checkbox"/> | <input type="checkbox"/> | Sensitive to sweets | <input type="checkbox"/> | <input type="checkbox"/> | Dental floss | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain in or near ears | <input type="checkbox"/> | <input type="checkbox"/> | Sensitive to biting | <input type="checkbox"/> | <input type="checkbox"/> | How often _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Jaw surgery | <input type="checkbox"/> | <input type="checkbox"/> | Food impaction | <input type="checkbox"/> | <input type="checkbox"/> | Flouride rinse | <input type="checkbox"/> | <input type="checkbox"/> |
| Broken jaw | <input type="checkbox"/> | <input type="checkbox"/> | Clenching/grinding | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Ortho treatment (braces) | <input type="checkbox"/> | <input type="checkbox"/> | Shifting teeth | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Bleeding/sore gums | <input type="checkbox"/> | <input type="checkbox"/> | Change in bite | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Unpleasant taste/bad breath | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | |
| Burning tongue/lips | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | |
| Frequent blisters on lips/in mouth | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | |

20. I attest to the accuracy of the information on both sides of this form:

Signature of patient X _____ Date _____
(parent or guardian)

21. **Consent:** I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I understand that dental treatment and use of anesthetic agents and medications embodies a certain risk. The more common complications are sensitivity, pain, abscess, infection, pulpal necrosis (tooth death), swelling, bleeding, bruising, and discoloration, temporary or permanent numbness and tingling, nausea, and allergic reactions. I understand that there is no warranty or guarantee as to any result or cure. I understand that I can receive a full recital of any and all possible risks attendant to my care by just asking. I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist or my physicians for reasons of consultation, referral, coordination with and/or transfer to additional providers.

Signature of patient X _____ Date _____
(parent or guardian)

HEALTH HISTORY UPDATE

NOTE CHANGES BELOW	PATIENT SIGNATURE	DATE