Caring Smiles
You'll love our care and your smile will show it!

Health History

Medical History: (Page 1 of 2)

In order to best address your dental needs, we need to know about your general health. Please answer the questions below. Leave the answer blank if you do not understand the question.

Have you ever experienced:

Yes	No	Dizziness / fainting spells?	Yes	No	Anaphylaxis or hives?
Yes	No	Shortness of breath?	Yes	No	Dry mouth?
Yes	No	Chest pain (angina)?	Yes	No	Headaches?
Yes	No	Seizures?	Yes	No	Ringing in ears?
Yes	No	Bleeding problems, bruising easily?	Yes	No	Sinus problems?
Yes	No	Joint pain or stiffness?	Yes	No	Cold sores or fever blisters?

Do you currently have, or have you ever had:

Yes	No	Replacement heart valves?	Yes	No	Hepatitis or other liver diseases?
Yes	No	Heart defects or heart disease?	Yes	No	Tumors or cancer?
Yes	No	High blood pressure?	Yes	No	Chemotherapy?
Yes	No	Heart attack?	Yes	No	Radiation treatments?
Yes	No	Pacemaker?	Yes	No	Kidney or bladder diseases?
Yes	No	Stroke or hardening of the arteries?	Yes	No	HIV or AIDS?
Yes	No	Diabetes?	Yes	No	Psychiatric care?
Yes	No	Thyroid or adrenal diseases?	Yes	No	Arthritis or rheumatism?
Yes	No	Reflux or other stomach problems?	Yes	No	Artificial joint?
Yes	No	Asthma, emphysema, or other lung diseases?	Yes	No	Complications from surgery?
Yes	No	Glaucoma or other eye diseases?	Yes	No	Contact lenses?
Yes	No	Serious head or neck injury?	Yes	No	Osteoporosis?
Yes	No	Sleep apnea?			

Are you allergic or sensitive to:

Yes	No	Antibiotics?	Yes	No	Local anesthetics?
Yes	No	Pain Medicines?	Yes	No	Metals or acrylic?
Yes	No	Latex?	Yes	No	Detergents?

Please list all drug, medication, and food allergies:

_____ _____ _____

_____ _____ _____

Women only:

Yes	No	Are you or could you be pregnant or nursing?	Yes	No	Taking birth control pills?

Do you use:

Yes	No	Recreational drugs?	Yes	No	Tobacco in any form?

Medical History: **(Page 2 of 2)**

Yes No **Has there been a change in your health in the last year?**

Yes No **Have you been hospitalized for a serious illness in the past three years?**

If yes, for what: _____

Yes No **Are you being treated by a physician now?**

If yes, for what: _____

Physician's name: _____

Please list any other diseases or medical problems that you have had or currently have that have not been covered on this form:

_____ _____ _____

_____ _____ _____

Please list all drugs, medications, over the counter medicines and natural remedies that you use:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Yes No **Have you ever taken any medicines containing bisphosphonates (Fosamax, Boniva, Actonel)?**

Dental History:

What is your main dental concern? _____

_____

What would you change about your smile? _____

_____

Do you currently have, or have you ever had:

Yes	No	Problems with previous dental treatment?	Yes	No	Difficulty getting numb?
Yes	No	Noises or pain in your jaw joint?	Yes	No	Dental anxiety?
Yes	No	Treatment for your jaw joints (TMJ)?	Yes	No	Orthodontic treatment (braces)?
Yes	No	Snoring or sleep apnea?	Yes	No	Periodontal (gum) disease?

Name of previous dentist: _____ **Date of last dental visit:** _____

Consent

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 status, and or the medications that I am using.

_____ _____

Signature **Date**