



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