PATIENT HEALTH HISTORY

Name:	Date of Birth:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will be receiving. Thank you for answering the following questions.

	YES	NO		YES	NO
Are you in good health?			Have you ever taken Fen-Phen/Redux?		
Have there been any changes in your general health within the past year?			Do you or have you used controlled substances?		
Are you now under the care of a physician?			Do you use tobacco?		
Date of your last physical exam:			Are you wearing contact lenses?		
Physician's Name: Address: Phone number:			Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?		
Have you ever been hospitalized for any surgical operations or serious illness? Please explain.			Do you have any disease, condition or problem not listed above that you think I should know about?		
Are you taking any medicine(s) including non-prescription medicine? If yes, what medicine(s) are you taking?			Medication(s):		
Have you had any abnormal bleeding?			WOMEN ONLY		
Do you bruise easily?			Are you pregnant or think you may be pregnant?		
Have you ever required a blood transfusion?			Are you nursing?		
Have you had a recent weight loss?			Are you taking birth control pills?		

Are you allergic to or have you had any reactions to any of the following:

	YES	NO		YES	NO
Local anesthetics like Novocaine			Iodine		
Penicillin or other antibiotics			Any metals (e.g. nickel, mercury, etc.)		
Sulfa drugs			Latex or rubber		
Barbiturates, sedatives or sleeping pills			Other (please list):		
Aspirin					

Do you have or have you ever had any of the following:

	YES	NO		YES	NO
Rheumatic heart disease or rheumatic fever			Joint replacement or implant		
Scarlet fever			Stomach ulcers		
Heart defects or heart murmur			Kidney trouble		
Heart trouble, heart attack, or angina			Tuberculosis		
Chest pain			Persistent cough		
Shortness of breath			Coughing that produces blood		
Pacemaker			Chemotherapy (cancer, leukemia)		
Heart surgery			Sexually transmitted diseases		
High/low blood pressure (circle which)			Epilepsy or seizures		
Congenital heart problems			Anemia		
Swelling of feet, ankles, or hands (circle)			Glaucoma		
Hepatitis, jaundice or liver disease			Nervousness		
Stroke			Tonsillitis		
Sinus trouble			Tumors		
Lung or breathing problems			Mental health care		
Asthma or Hay fever			Back problems		
Hives or skin rash			Chemical dependency		
Fainting or dizzy spells			Mitral valve prolapse		
Diabetes			Cortisone treatment		
AIDS or HIV infection			Cold sores/fever blisters		

Thyroid problems			Hypoglycemia		
Allergies			Eating Disorders		
Arthritis or Rheumatism					

PATIENT DENTAL HISTORY

Reason for this visit:	
When was your last dental visit?	
What was done then?	
How often did you visit your dentist before then?	
Previous dentist (name and location)	
Have you had a complete series of dental films (x-rays) taken? When and where?	
How often do you brush your teeth?	
How often do you floss your teeth?	
Is your drinking water fluoridated?	

	YES	NO		YES	NO
Do your gums bleed while brushing or flossing?			Do you clench or grind your teeth?		
Are your teeth sensitive to hot or cold liquids/foods?			Do you bite your lips or cheeks frequently?		
Are your teeth sensitive to sweet or sour liquids/foods?			Have you noticed any loosening of your teeth?		
Do you feel pain in any of your teeth?			Does food tend to become caught between your teeth?		
Do you have any sores or lumps in or near your mouth?			Have you ever had periodontal (gums) treatment?		
Have you ever experienced any of the following problems in your jaw?			Ever worn a bite plate or other appliance?		
Clicking			Have you ever had any difficult extractions in the past?		
Pain			Have you ever had any prolonged bleeding following extractions?		
Difficulty in opening or closing			Do you wear dentures or partials?		
Difficulty in chewing			If yes provide date of placement		
Do you have frequent headaches?			Have you ever received hygiene instructions regarding care of your teeth and gums?		

If you could change anything about your smile, what would you change?

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners.

Signature of patient/guardian if minor		Date:
Signature of doctor		Date: