PATIENT HEALTH HISTORY

PATIENT'S NAME____ BIRTH DATE__________________

CHIEF ORAL COMPLAINT____

DATE OF LAST DENTAL EXAM____________ PREVIOUS MAJOR DENTAL TREATMENT___YES___NO WHEN_____

PLEASE CHECK OFF THE ITEMS THAT YOU HAVE, HAD OR USE:

__Sensitivity to cold,hot,pressure,sweets
__Bleeding gums
__Food packing between teeth
__Clenching or grinding
__Burning of tongue
__Swelling or lumps in mouth
__Blisters on lips or mouth
__ History of TMJ issues or treatment
__Cheek biting

__Bad breath
__Unpleasant taste
__Unfavorable dental experience
__Complications from extractions
__Periodontal treatment
__Orthodontic treatment
__Mouth breathing
__Fingernail biting

__Tobacco Use
__Toothbrush____Firm____Med___Soft
__How often do you brush__________
__How often do you floss____________
__Dental/gum stimulators
__Water jet device
__Disclosing tablets or solution
__Fluoride supplements

MEDICAL HISTORY

Physicians Name & Phone #__________________________________ Date of last Physical________________

CHECK YES OR NO TO ANY OF THE FOLLOWING THAT YOU HAVE, HAD OR SUSPECTED:

YES	NO	YES	NO	YES	NO
__Current Pregnancy/Possibility	__	__Diabetes	__	__Prolonged Bleeding	__
__Heart Trouble	__	__Hepatitis	__	__Fainting Tendency	__
__Heart Murmur	__	__Liver Disease	__	__Radiation Treatment	__
__High/Low Blood Pressure	__	__Osteoporosis	__	__Prosthetic Joint Replacement	__
__Rheumatic Fever	__	__Cancer or Tumor	__	__Thyroid Disease	__
__Chest Pain	__	__Tuberculosis	__	__Glaucoma	__
__Stroke	__	__Lung Disease (COPD)	__	__Mental Disorder	__
__Shortness of Breath	__	__Arthritis	__	__Epilepsy	__
__Pacemaker	__	__Kidney/Bladder Trouble	__	__Venereal Disease	__
__HIV or AIDS	__	__Asthma or Hay Fever	__	__Sinus Trouble	__
__Anemia	__	__Blood Transfusion	__	__Blood Disease/Disorder	__

ARE YOU ALLERGIC TO OR DO YOU SUFFER ANY ILL EFFECTS FROM ANY OF THE FOLLOWING:

YES	NO	YES	NO	YES	NO
__Penicillin	__	__Codeine	__	__Sulfa	__
__Dental Anesthesia	__	__Aspirin	__	__Household Bleach	__
__Shellfish/Iodine	__	__Latex	__		
__Epinepherine	__			__Other____________________	

CHECK ANY OF THE FOLLOWING THAT YOU ARE TAKING OR HAVE TAKEN:

__*Bisphosphonates*
(Osteoporosis/Bone Density/Cancer)
__Blood Thinners
__Vitamins/Herbal Supplements

__Cortisone Drugs
__Tranquilizers
__Sedatives

__Anticoagulants
__Steroids
__Anti-Depressants

*ARE YOU TAKING ANY MEDICATIONS?______YES_____NO IF YES, PLEASE LIST/EXPLAIN*________________________

____

PATIENTS SIGNATURE____ DATE______________

DOCTOR/STAFF SIGNATURE____ DATE______________