

# HEALTH HISTORY

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age \_\_\_\_\_

Why are you now seeking dental treatment? \_\_\_\_\_

Please answer each question. Check yes or no. If in doubt, leave blank.

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 1. Are you in good health now? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you now under the care of a physician? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, what is the condition being treated? _____  |                          |                          |
| 3. Have you ever been hospitalized or had a serious illness? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, explain _____  |                          |                          |
| 4. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. (Women) Are you pregnant? If so, give due date _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you use tobacco in any form? If yes, how much _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you use alcoholic beverages (more than 2 drinks per day)? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have or have you ever had any of the following?  |                          |                          |

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| <b>GENERAL</b>                              |                          |                          |
| Tire easily, weakness .....                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Marked weight change .....                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Night sweats .....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent fever .....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>SKIN</b>                                 |                          |                          |
| Eruptions (rash) hives .....                | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in skin color .....                  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>EYES</b>                                 |                          |                          |
| Visual change .....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma .....                              | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>EARS</b>                                 |                          |                          |
| Loss of hearing .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Ringing in ears .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>NOSE</b>                                 |                          |                          |
| Frequent nosebleeds .....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus problems .....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>THROAT</b>                               |                          |                          |
| Soreness/hoarseness .....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>NERVOUS SYSTEM</b>                       |                          |                          |
| Stroke .....                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Headaches .....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Convulsions/epilepsy .....                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Numbness/tingling .....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizziness/fainting .....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Psychiatric treatment .....                 | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>RESPIRATORY</b>                          |                          |                          |
| Tuberculosis .....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema .....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma/hay fever .....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent cough .....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Sputum production (phlegm) .....            | <input type="checkbox"/> | <input type="checkbox"/> |
| Cough up bloody sputum .....                | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty breathing while lying down ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>ENDOCRINE</b>                            |                          |                          |
| Diabetes .....                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Family history of diabetes .....            | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid condition/goiter .....              | <input type="checkbox"/> | <input type="checkbox"/> |
| Other .....                                 | <input type="checkbox"/> | <input type="checkbox"/> |

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| <b>HEART/BLOOD VESSELS</b>                       |                          |                          |
| Rheumatic fever .....                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart murmur .....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest pain/discomfort .....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart attack/trouble .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of breath .....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Swelling of ankles .....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure .....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Congenital heart disease .....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral valve prolapse .....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial heart valve .....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Pacemaker .....                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart surgery .....                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Other .....                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>BONE/MUSCLES</b>                              |                          |                          |
| Arthritis/rheumatism .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial joints/limbs .....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>DIGESTIVE SYSTEM</b>                          |                          |                          |
| Hepatitis .....                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Jaundice .....                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Ulcers .....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in appetite .....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Black, bloody or pale stools .....               | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>URINARY</b>                                   |                          |                          |
| Kidney disease .....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Increase in frequency of urination (night) ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Burning on urination .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Urethral discharge .....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Bloody urine .....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Venereal disease .....                           | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>BLOOD</b>                                     |                          |                          |
| Bruise easily .....                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia .....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood transfusion .....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>OTHER</b>                                     |                          |                          |
| Radiation therapy .....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Chemotherapy .....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Tumors or growths .....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer .....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| HIV+ .....                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS .....                                       | <input type="checkbox"/> | <input type="checkbox"/> |

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

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

10. Are you taking any of the following?

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

If yes to any of the above, list **name** of medication and **dosage** below:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

11. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain \_\_\_\_\_

12. Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

13. Have you ever had any serious trouble associated with previous dental treatment? \_\_\_\_\_

14. Does dental treatment make you nervous? No \_\_\_\_\_ Slightly \_\_\_\_\_ Moderately \_\_\_\_\_ Extremely \_\_\_\_\_

15. Date of last dental visit \_\_\_\_\_

16. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? \_\_\_\_\_

If so, when? \_\_\_\_\_

17. Do you have or have you ever had any of the following?

MOUTH		YES	NO	TEETH		YES	NO
Bleeding, sore gums.....	<input type="checkbox"/>	<input type="checkbox"/>		Loose teeth .....	<input type="checkbox"/>	<input type="checkbox"/>	
Unpleasant taste/bad breath.....	<input type="checkbox"/>	<input type="checkbox"/>		Sensitive to hot.....	<input type="checkbox"/>	<input type="checkbox"/>	
Burning tongue/lips.....	<input type="checkbox"/>	<input type="checkbox"/>		Sensitive to cold.....	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent blisters, lips/mouth.....	<input type="checkbox"/>	<input type="checkbox"/>		Sensitive to sweets.....	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling/lumps in mouth.....	<input type="checkbox"/>	<input type="checkbox"/>		Sensitive to biting.....	<input type="checkbox"/>	<input type="checkbox"/>	
Ortho treatments (braces).....	<input type="checkbox"/>	<input type="checkbox"/>		Food impaction .....	<input type="checkbox"/>	<input type="checkbox"/>	
Biting cheeks/lips .....	<input type="checkbox"/>	<input type="checkbox"/>		Clenching/grinding.....	<input type="checkbox"/>	<input type="checkbox"/>	
Clicking/popping jaw.....	<input type="checkbox"/>	<input type="checkbox"/>		Shifting of teeth.....	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty opening or closing jaw .....	<input type="checkbox"/>	<input type="checkbox"/>		Change in bite.....	<input type="checkbox"/>	<input type="checkbox"/>	

**ORAL HYGIENE**

Do you use the following?	YES	NO	How often do you brush _____
Brush .....	<input type="checkbox"/>	<input type="checkbox"/>	Brush is: Soft <input type="checkbox"/> Medium <input type="checkbox"/> Hard <input type="checkbox"/>
Dental floss .....	<input type="checkbox"/>	<input type="checkbox"/>	
Fluoride rinse .....	<input type="checkbox"/>	<input type="checkbox"/>	
Other .....			

To the best of my knowledge, all of the preceding answers are true and correct.

If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient \_\_\_\_\_  
Parent, or Guardian \_\_\_\_\_ Date \_\_\_\_\_