PATIENT HEALTH HISTORY

Patient's Name: _____ Medical Alert: _____

MEDICAL HEALTH HISTORY

	YES	NO
1. Are you now or have you been under the care of a medical doctor during the past two years? If yes, please explain: _____	☐	☐
2. Have you been in the hospital in the last five years? If yes, please explain: _____	☐	☐
3. Have you had any major illnesses or operations? Please list and give approximate dates: _____	☐	☐
4. Physician's name: _____ Phone: _____ Address: _____ City _____ State: _____		
5. Are you aware of having an allergic or adverse reaction to penicillin, novocaine, codeine or other drugs? If yes, please explain. _____	☐	☐
6. Are you taking any medication, drugs or pills now, including regular doses of aspirin? If yes, please list name and dosage: _____	☐	☐

Are You Taking or Have You Taken?

YES	NO	
☐	☐	Tobacco in any form, packs/day?___
☐	☐	Alcoholic Beverages, glasses/week?___
☐	☐	Phen-Fen or Redux
☐	☐	Nutrasweet
☐	☐	Anti-Depressants
☐	☐	A.D.D. Medications
☐	☐	Cortisone Medicine (Oral, IM, Topical)
☐	☐	Radiation Therapy
☐	☐	Chemotherapy

Indicate which of the following you have had, or have at present?

YES	NO	
☐	☐	Heart (Congestive Heart Failure, Disease, Attack, Surgery)
☐	☐	Heart Murmur or MVP
☐	☐	Pacemaker
☐	☐	Prosthetic Heart Valve
☐	☐	Stroke
☐	☐	Rheumatic Fever
☐	☐	High or Low Blood Pressure
☐	☐	Cancer, Tumors
☐	☐	Diabetes or Hypoglycemia
☐	☐	Hearing Aid
☐	☐	Glaucoma or Eye Disease
☐	☐	Artificial Joints (hip, knee, etc.)
☐	☐	Implants (breast, TMJ, etc.)
☐	☐	Arthritis, Bone or Joint Problem
☐	☐	Hepatitis A, B, C, D, other
☐	☐	Jaundice, Liver Disease
☐	☐	Chronic Fatigue Syndrome
☐	☐	Fibromyalgia, Lupus, Schleroderma
☐	☐	HIV or AIDS
☐	☐	Anemia
☐	☐	Blood Transfusion
☐	☐	Hemophilia, Bleeding Disorder
☐	☐	Sickle Cell Disease
☐	☐	Epilepsy, Seizures, Convulsions
☐	☐	Psychiatric/Psychological Care
☐	☐	Depression or Anxiety
☐	☐	Neurological Disorders
☐	☐	Eating Disorder, Anorexia, Bulemia
☐	☐	Asthma or Hay Fever
☐	☐	Kidney Disorder
☐	☐	TB, Emphysema, Lung Disease
☐	☐	Thyroid Treatment
☐	☐	Herpes / Cold Sores
☐	☐	Venereal Disease
☐	☐	Ulcers or Stomach Problems
☐	☐	Contact Lenses
☐	☐	Latex Sensitivity
☐	☐	Allergies (Environmental)
☐	☐	Gained or lost 10 lbs. in the last year?
☐	☐	Family History of Cancer, Heart Disease, Diabetes, Periodontal Disease

Do you have any special condition or problem not listed on this form of which you feel we should be made aware? If so, please explain:

_____

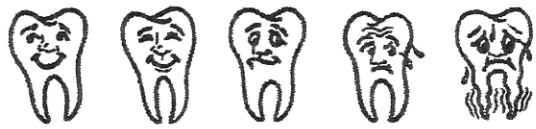
_____

Women Only:

☐	☐	Are you or could you be pregnant?
☐	☐	Taking birth control pills?

DENTAL HEALTH HISTORY

"Dental Bravery" Please circle one:



What is your major dental concern? _____

Date of last dental examination? _____ Name of dentist? _____

YES	NO	
☐	☐	Are you satisfied with your past dental care?
☐	☐	Would you like to retain your healthy natural teeth as long as possible?
☐	☐	Are you self conscious about the appearance of your teeth?
☐	☐	Does food catch between your teeth?
☐	☐	Has periodontal (gum) disease ever been diagnosed?
☐	☐	Do you feel that you will lose your teeth and eventually have to wear dentures?
☐	☐	Are any of your teeth sensitive to: ___hot ___cold ___sweets ___chewing
☐	☐	When brushing or flossing, do your gums feel: ___bleed ___irritated ___swollen
☐	☐	Do you frequently clench or grind your teeth?
☐	☐	Do you have discomfort in your: ___ears ___neck ___jaw ___TMJ / jaw joint
☐	☐	Do you snore at night?
☐	☐	Do you have frequent headaches?
☐	☐	Do you sleep well?
☐	☐	Can you breathe adequately through your nose?
☐	☐	Are you tired most of the time?
☐	☐	Are you aware of the tongue thrusting, lip biting, or any other adverse oral muscle habits?
☐	☐	Are there any questions or concerns you would like to discuss?

Signature: _____ Date: _____

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