

# 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?  |                          |                          |

## GENERAL

- |                             | YES                      | NO                       |
|-----------------------------|--------------------------|--------------------------|
| 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"/> |

## SKIN

- |                              |                          |                          |
|------------------------------|--------------------------|--------------------------|
| Eruptions (rash) hives ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in skin color .....   | <input type="checkbox"/> | <input type="checkbox"/> |

## EYES

- |                     |                          |                          |
|---------------------|--------------------------|--------------------------|
| Visual change ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma .....      | <input type="checkbox"/> | <input type="checkbox"/> |

## EARS

- |                       |                          |                          |
|-----------------------|--------------------------|--------------------------|
| Loss of hearing ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Ringing in ears ..... | <input type="checkbox"/> | <input type="checkbox"/> |

## NOSE

- |                           |                          |                          |
|---------------------------|--------------------------|--------------------------|
| Frequent nosebleeds ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus problems .....      | <input type="checkbox"/> | <input type="checkbox"/> |

## THROAT

- |                           |                          |                          |
|---------------------------|--------------------------|--------------------------|
| Soreness/hoarseness ..... | <input type="checkbox"/> | <input type="checkbox"/> |
|---------------------------|--------------------------|--------------------------|

## NERVOUS SYSTEM

- |                             |                          |                          |
|-----------------------------|--------------------------|--------------------------|
| 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"/> |

## RESPIRATORY

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 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"/> |

## ENDOCRINE

- |                                  |                          |                          |
|----------------------------------|--------------------------|--------------------------|
| 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"/> |

## HEART/BLOOD VESSELS

- |                                | YES                      | NO                       |
|--------------------------------|--------------------------|--------------------------|
| 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"/> |

## BONE/MUSCLES

- |                               |                          |                          |
|-------------------------------|--------------------------|--------------------------|
| Arthritis/rheumatism .....    | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial joints/limbs ..... | <input type="checkbox"/> | <input type="checkbox"/> |

## DIGESTIVE SYSTEM

- |                                    |                          |                          |
|------------------------------------|--------------------------|--------------------------|
| 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"/> |

## URINARY

- |   |                          |                          |
|---|--------------------------|--------------------------|
| Kidney disease .....                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Increase in frequency<br>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"/> |

## BLOOD

- |                         |                          |                          |
|-------------------------|--------------------------|--------------------------|
| Bruise easily .....     | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia .....            | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood transfusion ..... | <input type="checkbox"/> | <input type="checkbox"/> |

## OTHER

- |                         |                          |                          |
|-------------------------|--------------------------|--------------------------|
| Latex Sensitivity ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 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/ .....			Aspirin .....	<input type="checkbox"/>	<input type="checkbox"/>
cold remedies .....	<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
Bleeding, sore gums .....	<input type="checkbox"/>	<input type="checkbox"/>
Unpleasant taste/bad breath .....	<input type="checkbox"/>	<input type="checkbox"/>
Burning tongue/lips .....	<input type="checkbox"/>	<input type="checkbox"/>
Frequent blisters, lips/mouth .....	<input type="checkbox"/>	<input type="checkbox"/>
Swelling/lumps in mouth .....	<input type="checkbox"/>	<input type="checkbox"/>
Ortho treatments (braces).....	<input type="checkbox"/>	<input type="checkbox"/>
Biting cheeks/lips .....	<input type="checkbox"/>	<input type="checkbox"/>
Clicking/popping jaw .....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty opening or closing jaw .....	<input type="checkbox"/>	<input type="checkbox"/>

**TEETH**

	YES	NO
Loose teeth .....	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to hot .....	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to cold.....	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to sweets .....	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to biting .....	<input type="checkbox"/>	<input type="checkbox"/>
Food impaction .....	<input type="checkbox"/>	<input type="checkbox"/>
Clenching/grinding.....	<input type="checkbox"/>	<input type="checkbox"/>
Shifting of teeth .....	<input type="checkbox"/>	<input type="checkbox"/>
Change in bite .....	<input type="checkbox"/>	<input type="checkbox"/>

**ORAL HYGIENE**

Do you use the following?	YES	NO
Brush .....	<input type="checkbox"/>	<input type="checkbox"/>
Dental floss.....	<input type="checkbox"/>	<input type="checkbox"/>
Fluoride rinse .....	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

How often do you brush \_\_\_\_\_  
Brush is: Soft  Medium  Hard

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 \_\_\_\_\_