HEALTH HISTORY

Name:_____Birthdate:_____

Physician/Clinic:_____Office Phone:_____Last physical exam:_____

YES NO

☐ ☐ 1. Are you taking any prescribed medication(s) Or any non-prescription drugs (i.e. vitamins)? If yes, please list:

_____

_____

_____

☐ ☐ 2. Do you use tobacco? Kind? _____

☐ ☐ 3. Are you allergic to or have you ever reacted to:

☐ ☐ • Local Anesthetics (e.g. Novacaine)?

☐ ☐ • Penicillin or other anitibiotics?

☐ ☐ • Sulfa drugs?

☐ ☐ • Latex?

☐ ☐ • Aspirin or Codeine?

☐ ☐ • Metals (e.g. nickel)?

☐ ☐ • Other _____

4. **WOMEN ONLY**

☐ ☐ •Are you pregnant? Or think you might be?

•Are you on birth control or hormone replacements?

5. Carefully read the following and **CHECK** any that have ever affected you and circle if a choice:

☐ High/Low blood pressure
☐ Heart attack-date_____
☐ Heart disease
☐ Heart bypass
☐ Cardiac pacemaker
☐ Heart murmur
☐ AIDS or HIV infection
☐ Fainting
☐ Seizures/Epilepsy
☐ Kidney disease
☐ Liver disease
☐ Thyroid problems
☐ Ulcers/stomach problems
☐ Respiratory problems
☐ Asthma
☐ Rheumatic fever
☐ Dental Implants
☐ Diabetes
☐ Arthritis
☐ Nightguard

☐ Cancer/Type_____date_____
☐ Radiation/chemotherapy
☐ Tuberculosis
☐ Stroke
☐ Artificial joint/limbs Type_____ date_____
☐ Pins/Plates – date_____
☐ Hepatitis
☐ Herpes
☐ Chemical dependency
☐ Glaucoma
☐ Loss of hearing
☐ Recent weight loss/gain
☐ Eating disorders
☐ Allergies
☐ Anemia
☐ Sleep Apnea CPAP/Oral Sleep appliance
☐ Memory issues/Dementia
☐ Acid Reflux
☐ Other _____
_____

DENTAL HISTORY

Last dental visit?_____ For: ☐ Exam ☐ Cleaning ☐ Toothache ☐ Other_____

How do you feel about going to the dental office? ☐ Fine ☐ Slightly nervous ☐ Very uncomfortable

YES NO

☐ ☐ 1. Do your gums bleed while brushing?
☐ ☐ 2. Are your teeth sensitive?
☐ ☐ 3. Do you feel pain to any teeth?
☐ ☐ 4. Have you had any head, neck or jaw injuries?
☐ ☐ 5. Do you grind or clench your teeth?
☐ ☐ 6. Have you ever been told you have TMJ?
☐ ☐ 7. Have you ever had any prolonged bleeding following dental extractions?

YES NO

☐ ☐ 8. Have you ever had braces/orthodontic work?
☐ ☐ 9. Have you ever been told you have gum disease?
☐ ☐ 10. Have you had periodontal treatment?
☐ ☐ 11. Do you wear a Nightguard?
☐ ☐ 12.Any other dental concerns:_____
_____
_____

SIGNATURE_____ **DATE**_____

Comments:

_____

_____