Health History

Mark "Yes" or "No" to indicate if you have or have had any of the following:

Acid Reflux	☐Yes	☐No	Diabetes, Type_____	☐Yes	☐No	Radiation Treatment	☐Yes	☐No
AIDS/HIV	☐Yes	☐No	Emphysema	☐Yes	☐No	Date _____		
Anemia	☐Yes	☐No	Epilepsy	☐Yes	☐No	Respiratory Disease	☐Yes	☐No
Anorexia/Bulimia	☐Yes	☐No	Fainting or Dizziness	☐Yes	☐No	Rheumatic Fever	☐Yes	☐No
Arthritis, Osteo	☐Yes	☐No	Glaucoma	☐Yes	☐No	Shortness of Breath	☐Yes	☐No
Artificial Joints	☐Yes	☐No	Headaches	☐Yes	☐No	Sinus Trouble	☐Yes	☐No
Asthma	☐Yes	☐No	Heart Murmur	☐Yes	☐No	Skin Rash	☐Yes	☐No
Back Problems	☐Yes	☐No	Heart Problems	☐Yes	☐No	Special Diet	☐Yes	☐No
Bleeding Abnormally with			Type _____			Stroke or TIA	☐Yes	☐No
Extractions or Surgery	☐Yes	☐No	Hepatitis, Type_____	☐Yes	☐No	When_____		
Blood Disorder	☐Yes	☐No	Herpes, Type_____	☐Yes	☐No	Swollen Neck Glands	☐Yes	☐No
Type _____			High Blood Pressure	☐Yes	☐No	Thyroid Problems	☐Yes	☐No
Brain Injury	☐Yes	☐No	Kidney Disease	☐Yes	☐No	Tonsillitis	☐Yes	☐No
Cancer, Type_____	☐Yes	☐No	Liver Disease	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Chemical Dependency	☐Yes	☐No	Low Blood Pressure	☐Yes	☐No	Tumor or growth on head		
Chemotherapy	☐Yes	☐No	Mitral Valve Prolapse	☐Yes	☐No	or neck	☐Yes	☐No
Date _____			Nervous Problems	☐Yes	☐No	Ulcer	☐Yes	☐No
Circulatory Problems	☐Yes	☐No	Pacemaker, Yr. _____	☐Yes	☐No	Use Tobacco	☐Yes	☐No
Congenital Heart lesions	☐Yes	☐No	Psychiatric Care	☐Yes	☐No	Venereal Disease	☐Yes	☐No
Cortisone Treatments	☐Yes	☐No				Weight Loss, unexplained	☐Yes	☐No
Cough, Persistent/bloody	☐Yes	☐No						

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of lonimin, Adipex, Fastin (brand names of phentermine). Pondimin (fenfluramin and Redux (dexfenfluramine)? ☐Yes ☐No

Have you taken Fosomax or other Bisphosphates either oral or IV for treatment of Osteoporosis? ☐Yes ☐No

If yes: Are you aware of the dental risk associated with taking Bisphophonate drugs? ☐Yes ☐No _____
Signature

Women:

Are you pregnant? ☐Yes ☐No Due date: _____ Are you nursing? ☐Yes ☐No

Taking birth control pills? ☐Yes ☐No

Medications

List any medications you are currently taking:

_____

_____

_____

_____

Allergies

☐Acetaminophen (Tylenol)
☐Aspirin
☐Barbiturates (sleeping pills)
☐Codeine
☐Iodine
☐Ibuprofen
☐Latex
☐Local Anesthetic
☐Naproxin (Aleve)
☐Penicillin
☐Sulfa
Other_____

Dental History

Former Dentist_____ Date of last dental visit/x-rays_____

Concerning former dentist: What did you like best/least? _____

_____

If you could change anything concerning your smile, what would it be? _____

_____

Do you have problems with any of the following:

Bad breath	☐Yes	☐No	Fingernail biting	☐Yes	☐No	Mouth breathing	☐Yes	☐No
Bleeding gums	☐Yes	☐No	Food collection			Orthodontic treatment	☐Yes	☐No
Burning sensation on			between teeth	☐Yes	☐No	Periodontal treatment	☐Yes	☐No
tongue	☐Yes	☐No	Grind teeth	☐Yes	☐No	Sensitivity _____	☐Yes	☐No
Chew on one side of			Gums swollen/tender	☐Yes	☐No	Sores or growths in your		
mouth	☐Yes	☐No	Jaw pain	☐Yes	☐No	mouth	☐Yes	☐No
Clicking or popping			Lip or cheek biting	☐Yes	☐No	Tongue or lip piercing	☐Yes	☐No
Jaw	☐Yes	☐No	Loose or broken teeth	☐Yes	☐No			
Dry mouth	☐Yes	☐No						

Patient Signature_____ Date _____