Health History

PLEASE PRINT PATIENT'S NAME: _____ DATE OF BIRTH:_____
Primary physician's name: _____ Date of last visit: _____
Former Dentist's Name: _____ Date of last visit: _____

Please circle Yes (Y) or No (N) to indicate if you have had any of the following:

Bad breath	Y	N	Food collection between teeth	Y	N	Orthodontic treatment	Y	N
Bleeding gums	Y	N	Foreign objects	Y	N	Pain around ear	Y	N
Blisters on lips/mouth	Y	N	Grinding teeth	Y	N	Periodontal treatment	Y	N
Burning sensation on tongue	Y	N	Gums swollen or tender	Y	N	Sensitivity to cold	Y	N
Chew on one side of mouth	Y	N	Jaw pain or tiredness	Y	N	Sensitivity to heat	Y	N
Cigarette, pipe, cigar smoking	Y	N	Lip or cheek biting	Y	N	Sensitivity to sweets	Y	N
Clicking or popping jaw	Y	N	Loose teeth or broken fillings	Y	N	Sensitivity when biting	Y	N
Dry mouth	Y	N	Mouth breathing	Y	N	Sores or growths in your mouth	Y	N
Fingernail biting	Y	N	Mouth pain, brushing	Y	N	Bubble or pimple on gum	Y	N

Reason for today's visit_____
How often do you floss? _____ How often do you brush? _____

Please circle Yes (Y) or No (N) to indicate if you have had problems with or are presently complaining of any of the following:

Abdominal Discomfort	Y	N	Circulatory problems	Y	N	High blood pressure	Y	N	Persistent Cough	Y	N
Acid Reflux	Y	N	Congenital heart lesions	Y	N	Hay fever	Y	N	Radiation treatment	Y	N
ADD	Y	N	Cortisone treatments	Y	N	Head/Neck radiation	Y	N	Recent Surgery	Y	N
ADHD	Y	N	Colitis	Y	N	Indigestion	Y	N	Respiratory disease	Y	N
AIDS/HIV	Y	N	Cough, persistent or bloody	Y	N	Jaundice	Y	N	Rheumatic fever	Y	N
Alcohol Abuse	Y	N	Cystic Fibrosis	Y	N	Joint Replacement	Y	N	Scarlet Fever	Y	N
Anemia	Y	N	Diabetes	Y	N	Kidney disease	Y	N	Shortness of breath	Y	N
Anxiety	Y	N	Dental Visit Related Anxiety	Y	N	Kidney stones	Y	N	Sinus trouble	Y	N
Arthritis/Rheumatism	Y	N	Depression	Y	N	Liver disease	Y	N	Skin rash/disorders	Y	N
Artificial heart valves	Y	N	Drug abuse	Y	N	Low blood pressure	Y	N	Special diet	Y	N
Artificial joints	Y	N	Emphysema	Y	N	Light-headedness	Y	N	Stroke	Y	N
Asthma	Y	N	Epilepsy	Y	N	Mitral valve prolapsed	Y	N	Swollen feet or ankles	Y	N
Autism	Y	N	Fainting or dizziness	Y	N	Muscular Dystrophy	Y	N	Swollen neck glands	Y	N
Back problems	Y	N	Glaucoma	Y	N	Nervous problems	Y	N	Thyroid problems	Y	N
Bleeding abnormally	Y	N	Headaches	Y	N	Nausea	Y	N	Tonsillitis	Y	N
Blood disease	Y	N	Heart murmur	Y	N	Osteoporosis	Y	N	Tuberculosis	Y	N
Bronchitis	Y	N	Heart problems	Y	N	Pacemaker	Y	N	Tumor or growths	Y	N
Cancer	Y	N	Hepatitis	Y	N	Psychiatric care	Y	N	Ulcer	Y	N
Chemical dependency	Y	N	*If **YES**, please circle type **A B C**			Palpitations	Y	N	Venereal Disease	Y	N
Chemotherapy	Y	N	Herpes	Y	N	Pneumonia	Y	N	Weight loss or gain	Y	N

MEDICATIONS

List any Medications you are currently taking:

_____

_____

ALLERGIES

( ) Aspirin **( ) Local anesthetic**
( ) Barbiturates (sleeping pills) **( ) Penicillin**
( ) Codeine **( ) Sulfa**
( ) Latex **( ) Iodine**
( ) Bleach **( ) Other _____**
Food allergies: _____

WOMEN: Are you pregnant? ____ Due Date? _____ Are you nursing? _____ On birth control pills? _____

I acknowledge that I have received the Patient Information brochure and the Notice of Privacy Practices.

_____ _____
(PATIENT name) **(date)**

_____ _____
(PROVIDER signature) **(date)**