

MEDICAL AND DENTAL HEALTH HISTORY

PATIENT NAME: _____

DATE: _____

Have you had any of the following at any time?

- | | | |
|--------------------------|--------------------------|--|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain on exertion, angina |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker or prosthetic heart valve |
| <input type="checkbox"/> | <input type="checkbox"/> | Prosthetic joint implants |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Low blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood or bleeding problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Breathing or respiratory problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Treated for growth, tumor or cancer
(surgery, radiation, chemotherapy) |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful or swollen joints |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic infections |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin problems, hives, or rashes |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid, kidney or liver disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach or intestinal problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures, convulsions, or fainting spells |
| <input type="checkbox"/> | <input type="checkbox"/> | Treated for nervous condition |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever blisters, cold sores |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaundice |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcoholism |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Herpes |
| <input type="checkbox"/> | <input type="checkbox"/> | Venereal disease (gonorrhea, syphilis) |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug addiction |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Leukemia |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV positive |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing Aid |
| <input type="checkbox"/> | <input type="checkbox"/> | Tobacco Habit |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any allergies? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Latex Allergy or Sensitivity? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any adverse or unusual reaction to Penicillin,
aspirin, codeine, dental anesthetic, or other medications? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you presently under a physician's care? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you presently taking any medications? (including aspirin) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | (Women) Are you pregnant? Due date _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> | <input type="checkbox"/> | (Child) Are your immunizations current? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been hospitalized? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you in good health? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any disease, condition, or problem not listed that
we should know about? _____ |

Physician's Name _____

Physician's Phone _____

Physician's Address _____

OFFICE USE ONLY

Health Update		
Date	Health or Medication Changes	
		BP
		Pulse
		H/Wt

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

- | | |
|---|--|
| <input type="checkbox"/> younger | <input type="checkbox"/> cover stains |
| <input type="checkbox"/> lengthen teeth | <input type="checkbox"/> replace missing teeth |
| <input type="checkbox"/> close spaces | <input type="checkbox"/> straighten teeth |
| <input type="checkbox"/> brighter | <input type="checkbox"/> repair chipped teeth |
| <input type="checkbox"/> shorten teeth | |
| <input type="checkbox"/> other _____ | |

Please check any of the following conditions that apply to you:

- bad breath
- bleeding gums
- clicking or popping jaw
- food collection between teeth
- grinding teeth
- loose teeth or broken fillings
- periodontal treatment
- sensitivity to cold
- sensitivity to hot
- sensitivity to sweets
- sensitivity when biting
- sores or growths in your mouth

The above information is accurate to the best of my knowledge.

Patient Signature _____