Dental History

PLEASE CHECK (X) IF YOU HAVE OR USE ANY OF THE FOLLOWING. ALL RESPONSES ARE CONFIDENTIAL.

( ) Teeth sensitive to cold, heat, sweets, pressure
( ) Bleeding gums. How long? _____
( ) Food Impaction
( ) Clenching or grinding
( ) Burning of tongue
( ) Swelling or lumps in mouth
( ) Frequent blisters on lips or mouth
( ) Pain around ear
( ) Unusual sounds in ear while eating
( ) Complications from extractions
( ) Periodontal treatment
( ) Orthodontic treatment
( ) Clicking or popping of jaw joint, pain near the ear, difficulty opening mouth

( ) Bad Breath
( ) Unpleasant taste
( ) Unfavorable dental experience
( ) Fingernail or cheek biting
( ) Mouth breathing/Dry mouth
( ) Cigarettes/pipe or cigar smoking
Number: 1-10/day 10-20/day 20-40/day
( ) Dip or chew tobacco
( ) Chew gum daily
( ) Coffee or tea with sugar daily
circle one: 1 2 3 4 5 more
( ) Soft drinks, juice or sports drink daily
circle one: 1 2 3 4 5 more
( ) Sweets daily; Number? _____

( ) Texture of toothbrush _____
( ) Dental floss
( ) Interdental stimulator
( ) Water jet device
( ) Disclosing tablets or solution
( ) Fluoride supplements

If not a new patient, PLEASE UPDATE your:

Address _____

_____

Phone numbers / Cell_____

Work / Home_____/_____

Email_____

Medical History

Physician Name: _____ Physician Phone**:** _____Date of last exam: _____

PLEASE CHECK (X) ALL THAT APPLY (PAST OR CURRENT) AND USE THE SPACE BELOW TO EXPLAIN ANY CHECKED.

( ) Acid Reflux
( ) ADHD
( ) Alcoholism
( ) **Allergies to drugs - LIST ON OTHER SIDE**
( ) **Anesthetics reactions- EXPLAIN BELOW**
( ) Anemia or blood problems
( ) Antihistamines or Decongestants
( ) Arthritis
( ) Aspirin or Ibuprofen (Motrin, Naprosyn)
( ) **Asthma-EXPLAIN ON OTHER SIDE**
( ) Cancer
( ) Channel (Calcium) Blockers, Procardia
( ) **Diabetes-EXPLAIN ON OTHER SIDE**
( ) Digitalis, Inderal, Nitroglycerin
( ) Excessive Bleeding or taking **blood thinners**
( ) Eye Disorders
( ) Hay Fever/other allergies
( ) **Heart Ailment-EXPLAIN ON OTHER SIDE**
( ) Heartburn

( ) Hiatal Hernia
( ) High Blood Pressure
( ) History of Anxiety
( ) History of bio phosphates
( ) History of Meth use
( ) HIV Positive
( ) Implants anywhere in your body
( ) Insulin/Diabetes etc.
( ) Joint Replacement
( ) Kidney Problems
( ) **Latex Allergy**
( ) Liver Problems/Hepatitis
( ) Lung Disease, Emphysema, Bronchitis, Pneumonia, Tuberculosis, chest pain, shortness of breath
( ) Malignancies
( ) Marijuana or other "street drugs"
( ) Neurological Problems
( ) **Other-EXPLAIN IN SPACE BELOW**

( ) Panic Attacks
( ) Pre-medicate for dental work
( ) Pregnant – If yes, what trimester _____
( ) Psychiatric care/emotional problems
( ) Radiation Treatments
( ) Radiation Head/Neck
( ) Recurring Infections of any kind
( ) Rheumatic Fever
( ) **Seizures-EXPLAIN ON OTHER SIDE**
( ) Sinus problems
( ) Sleep Apnea or other sleep problems
( ) Steroids (Cortisone, etc.)
( ) Stroke
( ) Sulfa Allergy
( ) Tranquilizers (Valium, etc)
( ) Thyroid
( ) Tonsillitis
( ) Ulcer or Colitis
( ) Venereal Disease

List all MEDICATIONS you are taking, including dosage, in the space below. Please also use this space to explain, provide additional information, and/or describe medical considerations not included in the list above. If needed, more space is available at the top of the other side of this form.

_____

_____

_____

For Women Using Oral Contraceptives: Antibiotics may interfere with the effectiveness of oral contraceptives and you will need to use an alternate form of birth control for one complete cycle after antibiotics given as part of your dental care treatment. Consult with your physician for further guidance.

I understand the importance of an accurate health history to assist the doctor in providing the best care possible and have provided complete and accurate information about my dental and medical health. I have read or, if requested, received a copy of the office's privacy, security and breach notification policies.

Patient Name _____ Responsible Party (if different)_____

Responsible Party Relationship _____ Signature _____ Date _____
if not patient.

Health History Updates – this area used only for visits after the date shown above (when this form first signed)

Today's Date	Health or Medication Change (use back side of this form if more space is needed.)	Initial

USE THE SPACE BELOW IF NEEDED TO SUPPLEMENT INFORMATION PROVIDED ON THE OTHER SIDE OF THIS FORM.

_____

_____

_____

IF YOU CHECKED A CONDITION HIGHLIGHTED ON THE OTHER SIDE, PLEASE ANSWER THE RELATED QUESTIONS BELOW.

DRUG ALLERGIES: _____

ASTHMA

1. What brings on an attack?
   _____
2. How often do you get an attack and how long does one typically last?
   _____
3. What drugs do you use to prevent acute episodes? What is the usual number of doses needed?
   _____
4. Have you ever been hospitalized for your Asthma?
   _____
5. Do carry an inhaler? Do you have your inhaler with you? (Please bring it to your appointments if stress triggers an episode.)
   _____

DIABETES

1. Do you use oral medication or insulin? What dosage?
   _____
2. How well controlled is your Diabetes?
   _____
3. How often do you check your blood sugar? What was your last A1C level and when was it taken?
   _____
4. When did you last eat and when are you due for your next snack or meal?
   _____

HEART

1. Please briefly describe your heart condition.
   _____
2. Who is your cardiologist? When were you last evaluated?
   _____
3. If you have Angina, how frequently do you have an episode? How long does the Angina last?
   _____
4. If you have Angina, what typically triggers it? How quickly does nitroglycerin relieve an episode? (Please bring it to appointments.)
   _____

SEIZURES

1. What type of seizures do you have? How often?
   _____
2. How long do your seizures last? What is your aura? (generalized tonicclonic)
   _____
3. Did you take your medication today?
   _____

OFFICE USE ONLY -- COMPLETE THIS SECTION ONLY IF REQUESTED BY CLINIC STAFF

I have been informed of the need for one or more radiographic images to ensure a thorough oral examination. It is my choice to refuse the/these procedure(s) at this time and I am doing so with full understanding that it may compromise the doctor's ability to detect and diagnose oral health considerations which could affect my teeth, surrounding tissue and bone, and overall health.

Name of patient _____Responsible Party (if different) _____Relationship_____

Signature _____Today's Date _____