Today's Date_____

Patient's Name_____ **Date of Birth**____/____/_____

Gender ____**Height**_____ **Weight**_____**Email** _____**SSN:**_____

Street Address_____ **State**_____ **Zip Code**_____

Mobile Phone Number_____ **Home Phone Number** _____

Emergency Contact Name _____**Emergency Contact Phone Number**_____

An accurate and complete health history will assist in coordinating your dental care.

Please speak with the doctor or staff if there are any questions about this form.

DENTAL HISTORY

Please describe your current dental health: Excellent Good Fair Poor

Please describe why you are in the office today_____

_____

Have there been any changes in your dental health in the past year? Yes / No

If yes, please describe_____

_____

Are you having any dental discomfort at this time? Yes / No If yes, please describe;_____

Where is the pain? Upper jaw Lower jaw / Right side Left side

The pain is; Mild Moderate Severe / Intermittent Constant / Sharp Stabbing Throbbing

Other; _____

Have you had any adverse effects from dental treatment? Yes / No

If yes, please describe: _____

_____

Date of last dental visit? ____ (month) / _____ (year)

Dental History

Do you have or have you ever had any of the following:

Bleeding, sore gums?	**Yes / No**	**Shifting in bite?**	**Yes / No**
Unpleasant taste/bad breath?	**Yes / No**	**Change in bite?**	**Yes / No**
Swelling/lumps in mouth?	**Yes / No**	**Burning tongue/lips?**	**Yes / No**
Orthodontic treatment (braces?)	**Yes / No**	**Frequent blister, lips/mouth?**	**Yes / No**
Clenching/grinding?	**Yes / No**	**Sensitive teeth (hot or cold?)**	**Yes / No**
Sensitive to sweets?	**Yes / No**	**Clicking/popping jaw?**	**Yes / No**
Sensitive to biting?	**Yes / No**	**Difficulty opening or closing jaw?**	**Yes / No**
Food Impaction?	**Yes / No**	**Loose teeth?**	**Yes / No**
Biting cheeks/lips?	**Yes / No**	**Inability to chew normal foods?**	**Yes / No**
Poorly fitting denture / prosthesis?	**Yes / No**	**Difficulty Chewing?**	**Yes / No**

MEDICAL HISTORY

Please describe your current overall health: Excellent Good Fair Poor

Have there been any changes in your general health in the past year? Yes / No

If yes, please describe: _____

Are you now under a doctor's care for a medical condition? Yes / No

If yes, please describe _____

Date of last physical exam? ____/____/____

Physician Name and Contact Details (if applicable)

Primary Care Physician _____ **Phone number;**_____

Cardiologist; _____ **Phone number;** _____

Oncologist; _____ **Phone number;** _____

Obstetrician / Gynecologist; _____ **Phone number;**_____

Other Specialist;(_____**);** _____ **Phone number;** _____

Have you ever been hospitalized or had a serious illness? Yes / No

If yes, please describe _____

Do you have, or have you ever had, any of the following conditions:

Congenital Heart Disease, Cardiovascular Disease – High blood pressure, low blood pressure, angina, coronary artery disease, congestive heart failure, irregular heartbeat, heart attack, heart surgery? Stroke? Pacemaker / Defibrillator?	Yes / No Yes / No Yes / No	**Respiratory Disease** – Asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, severe coughing? Sinus or nasal problems? Sleep apnea? Shortness of breath, chest pain?	Yes / No Yes / No Yes / No Yes / No
Implants placed anywhere in the body Heart valve, pacemaker, hip, knee, breast? When? _____	Yes / No	**Bleeding disorder or taking Blood Thinners** – Anemia, bleeding tendency, blood transfusion, bruise easily?	Yes / No
Kidney disease or kidney failure, requiring dialysis?	Yes / No	**Liver disease** – Jaundice, hepatitis A, B, or C?	Yes / No
Gastro-Intestinal disease – GERD, stomach ulcers, Crohn's Disease ulcerative colitis?	Yes / No	**Musculoskeletal** – Arthritis, Fibromyalgia, Degenerative Joint Disease? Where? _____	Yes / No
Endocrine diseases – Diabetes?	Yes / No	**Osteoporosis or osteopenia**?	Yes / No
Endocrine diseases - Thyroid disease?	Yes / No	**Cancer**? If yes, type_____ Diagnosis date_____ Treatments_____	Yes / No
Glaucoma?	Yes / No		
Significant weight loss or gain?	Yes / No		

PAST SURGICAL HISTORY

Have you ever had surgery? Yes / No **If yes, please give details below.**

Surgery Performed	Date (month / year)	Surgery Performed	Date (month / year)
_____	____/____	_____	____/____
_____	____/____	_____	____/____
_____	____/____	_____	____/____
_____	____/____	_____	____/____
_____	____/____	_____	____/____

MEDICATIONS

Are you currently prescribed or taking any of the following:

Antibiotics?	Yes / No	Prescription pain medication?	Yes / No
Anticoagulants or blood thinners?	Yes / No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes / No
Heart medications?	Yes / No	Insulin or oral anti-diabetic drugs?	Yes / No
Steroids – like cortisone or prednisone?	Yes / No	Blood pressure medications?	Yes / No
Antianxiety agents, antidepressants, or other psychiatric medications?	Yes / No	Bisphosphonates or other medications to strengthen your bones?	Yes / No
Cancer or chemotherapy drugs?	Yes / No	Any other medications or supplements?	Yes / No

PHARMACY DETAILS

NAME OF PHARMACY:_____**CITY:** _____**STATE:** _____

MEDICATIONS (continued): Please list all the specific prescription medications indicated above and/or any other medications not listed above; diet drugs, over the counter medications, herbal/holistic remedies, vitamins, or minerals:

Medication and dose	Medication and dose

ALLERGIES

Are you allergic to or have you had an adverse reaction to:

Latex?	Yes / No	Codeine or other pain control medications?	Yes / No
Food or food products?	Yes / No	Aspirin, ibuprofen (Motrin), or naproxen (Aleve)?	Yes / No
Sedatives or barbiturates?	Yes / No	Penicillin or other antibiotics?	Yes / No
Any other medications?	Yes / No	Any other allergies?	Yes / No

If yes, please describe_____

FEMALE PATIENTS Are you pregnant? Yes / No Is there any chance you might be pregnant? Yes / No

SOCIAL HISTORY

Have you ever smoked, vaped or chewed tobacco? Yes / No
If yes, for how long? _____

Have you ever sought professional care or been hospitalized for:
- Substance abuse Yes / No
- Emotional disorders Yes / No
- Alcoholism Yes / No

Do you use:
- Alcohol? Yes / No If yes, how often per week? _____
- Marijuana? Yes / No If yes, how often per week? _____
- Recreational drugs? Yes / No If yes, how often per week? _____

DO YOU WISH TO TALK TO THE DOCTOR ABOUT ANYTHING IN PRIVATE? Yes / No

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I understand the importance of a truthful and complete health history to assist my doctor in providing coordinated care. To the best of my knowledge, the above information is complete and correct.

_____

Signature of patient, parent, guardian

_____

Printed name of patient, parent, guardian/Relationship

_____

Date

For office staff use - HEALTH HISTORY REVIEW

Date Comments Doctor's Signature

_____

_____

_____

_____

For office staff use - ADDITIONAL CLINICAL DOCUMENTATION

_____

_____

_____