

Patient Health History

Patients Name: _____

Date: _____

Dental History

Reason for today's visit _____ Previous Dentist name _____ Date of last dental visit _____
 Date of last dental x-rays _____ Did you bring them with you today? Yes No If not, did you request them to be sent here? Yes No
 Have you ever been told to take an antibiotic prior to dental treatment? Yes No

Circle any of the following that pertain to you:

Bad Breath	Bleeding/Swollen Gums	Blisters lips/mouth	Chewing problems	Burning sensation on tongue	Smoker
Fingernail biting	Food collecting between teeth	Grinding teeth	Lip/cheek biting	Loose teeth/broken fillings	Mouth breathing
Mouth pain	Ortho treatment	Pain around ear	Periodontal Tx	Sensitive hot/cold/sweets	Sores/growths in mouth
Thumb Sucking	Dry mouth	Flossing Frequency		Brushing frequency	

Please circle either yes or no to any of the following that apply to the patient:

AIDS/HIV	Y	N
ALCOHOL/DRUG ABUSE	Y	N
ANEMIA	Y	N
ARTHRITIS	Y	N
ARTIFICIAL HEART VALVE	Y	N
ARTIFICIAL JOINTS	Y	N
ASTHMA	Y	N
BACK PROBLEMS	Y	N
BLEEDING PROBLEMS	Y	N
BLOOD DISEASE	Y	N
CANCER	Y	N
CHEMICAL DEPENDENCY	Y	N
CHEMOTHERAPY	Y	N
CHEST PAIN	Y	N
CIRCULATORY PROBLEMS	Y	N
CONGENITAL HEART PROB.	Y	N
CONVULSIONS	Y	N
CORTISONE TREATMENTS	Y	N
COSMETIC SURGERY	Y	N
COUGH, PERSISTENT OR BLOODY	Y	N
DIABETES/HYPOGLYCEMIA	Y	N
DIFFICULTY BREATHING	Y	N
EMPHYSEMA	Y	N
EPILEPSY	Y	N
FAINING OR DIZZINESS	Y	N
GLAUCOMA	Y	N

HANDICAPS OR DISABILITIES	Y	N
HEADACHES	Y	N
HEART ATTACK	Y	N
HEART DISEASE	Y	N
HEART MURMUR	Y	N
HEART PACEMAKER	Y	N
HEPATITIS TYPE	Y	N
HERPES	Y	N
HIGH/LOW BLOOD PRESSURE	Y	N
JAUNDICE	Y	N
JAW PAIN	Y	N
KIDNEY DISEASE	Y	N
LEUKEMIA	Y	N
LIVER DISEASE	Y	N
MITRAL VALVE PROLAPSE	Y	N
NERVOUS PROBLEMS	Y	N
PSYCHIATRIC CARE	Y	N
RADIATION TREATMENT	Y	N
RESPIRATORY DISEASE	Y	N

RHEUMATIC FEVER	Y	N
SCARLET FEVER	Y	N
SHINGLES	Y	N
SHORTNESS OF BREATH	Y	N
SINUS TROUBLE	Y	N
SKIN RASH	Y	N
SPECIAL DIET	Y	N
STOMACH PROBLEMS	Y	N
STROKE	Y	N
SWOLLEN FEET OR ANKLES	Y	N
SWOLLEN NECK GLANDS	Y	N
THYROID PROBLEMS	Y	N
TONSILITIS	Y	N
TUBERCULOSIS	Y	N
TUMOR	Y	N
GROWTH ON HEAD/NECK	Y	N
ULCER	Y	N
VENEREAL DISEASE	Y	N
WEIGHT LOSS UNEXPLAINED	Y	N

WOMEN ONLY:

Are you pregnant? Yes No Due Date: _____ Name of OB/GYN _____ Are you nursing? Yes No
 Are you taking Birth control pills? Yes No

Medical Questions and Allergy Questions

Are you allergic to any of the following Aspirin Amoxicillin Barbiturates Codeine Dental Anesthetics
 Iodine Latex Penicillin Sulfa Tetracycline other allergies please list: _____

Have you had any recent surgeries? If so, please list and give dates: _____

Have you been in the hospital in the last 2 yrs? Yes No When: _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These would include combinations of Lonimin, Adipex, Fastin (brand names of Phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine) Yes No

MEDICATIONS

List any medications you are currently taking. Please include the dosage and the frequency.

Pharmacy name: _____ Pharmacy Phone _____