HEALTH HISTORY Name_____ Date_____

1. Are you currently under the care of a physician (not routine care)? YES NO
2. Do you smoke or use tobacco in any other form? YES NO
3. Have you ever taken Phen-Fen? YES NO
4. Are you currently in pain? YES NO
5. Do you require antibiotics before dental treatment? YES NO
6. Have you ever had a serious or difficult problem associated with any previous dental work? YES NO
7. Do you now or have you ever experienced pain or discomfort in your jaw (TMJ/TMD)? YES NO
8. Do you like your smile? YES NO
9. Would you like whiter teeth? YES NO
10. Do your gums ever bleed? YES NO
11. How many times a week do you floss? _____
12. How many times a day do you brush? _____
13. What kind of toothbrush do you use? Manual Electric
14. When was your last dental appointment? _____

For Women:
Are you pregnant? YES NO Week # _____
Are you nursing? YES NO

Circle any of the following diseases or medical problems that you have or have had? None

Abnormal Bleeding
Alcohol/Drug Abuse
Anemia
Arthritis
Artificial Bone/Joints/Valves
Asthma
Blood Transfusion
Cancer/Chemotherapy
Colitis
Congenital Heart Defect
Diabetes
Difficulty Breathing
Emphysema
Epilepsy
Fainting Spells
Frequent Headaches
Gastric Bypass/Lap Band
Glaucoma
Hay Fever
Heart Attack
Heart Murmur
Heart Surgery
Hemophilia
Hepatitis
Herpes/Fever Blisters
High Blood Pressure
HIV+/ AIDS
Hospitalized for any reason
Kidney Problems
Liver Disease
Low Blood Pressure
Mitral Valve Prolapse
Pacemaker
Psychiatric Problems
Radiation Treatment
Rheumatic/Scarlet Fever
Seizures
Shingles
Sickle Cell Disease/Traits
Sinus Problems
Stroke When:
Tuberculosis (TB)
Thyroid Problems
Ulcers
Venereal Disease
Other: _____

Are you allergic to any of the following? (Please circle)

No known allergies
Aspirin
Codeine
Dental Anesthetics
Erythromycin
Latex
Metals
Penicillin / Amoxicillin
Tetracycline
Sulfa
Other: _____

Are you taking any prescription or over-the-counter drugs? Please list below <u>with the reason for taking them</u>.

_____ _____
_____ _____
_____ _____

I understand that the information that I have given today is correct and to the best of my knowledge. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Patient/Parent Signature_____ Date_____

Date_____ Comments_____Initials_____
Date_____ Comments_____Initials_____
Date_____ Comments_____Initials_____
Date _____ Comments_____Initials_____