PATIENT INFORMATION

Name: _____ Date of Birth: _____
Residential Address _____ City _____ State _____ Zip _____
Phone _____ Referred by: _____
Your Dentist: _____ City _____ How long? _____
Your Physician: _____ City _____ Phone: _____
Date of Last Physical Examination: _____ Purpose of examination: _____

MEDICAL HEALTH HISTORY

History of smoking? ☐ Yes ☐ No If **YES**, how many per day: _____ How long? _____ Quit date: _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

HEART PROBLEMS
Chest Pain ☐
High Blood Pressure ☐
Heart Murmur ☐
Angina Pectoris ☐
Taking Heart Medication ☐
Rheumatic Fever ☐
Pacemaker ☐
Artificial Heart Valve ☐
Mitral Valve Prolapse ☐
Congenital Heart Lesions ☐
Heart Attack ☐
Bypass ☐

Stroke ☐
Diabetes ☐
Stomach Ulcers ☐
Kidney Trouble ☐
Fainting Spells or Epilepsy ☐
Glaucoma ☐

Infectious Diseases ☐
HIV Positive ☐
AIDS ☐
Hepatitis (A) (B) (C) ☐
Liver Disease ☐
Yellow Jaundice ☐
Cold Sores ☐

BONE OR JOINT PROBLEMS
Joint Replacement ☐
Implants ☐
Arthritis ☐
Cortisone Medicine ☐
Pain in Joints ☐
Osteoporosis ☐

RESPIRATORY DISEASE
Tuberculosis ☐
Emphysema ☐
Asthma ☐
Sinus Problems ☐
Hay Fever ☐

BLOOD PROBLEMS
Easy Bruising ☐
Blood Transfusion ☐
Abnormal Bleeding ☐
Hemophilia ☐
Anemia ☐

Cancer/Tumor ☐
Chemotherapy ☐
Radiation Treatment ☐

Physical Limitation ☐
Hearing Impairment ☐
Psychiatric Treatment ☐
Depression ☐
Anxiety Disorder ☐

Drug Addiction ☐
Alcoholism ☐
Chewing Tobacco ☐

AN ALLERGIC REACTION TO:
Aspirin ☐
Codeine ☐
Dental Anesthetic ☐
Erythromycin ☐
Penicillin ☐
Sedatives or Sleeping Pills ☐
Sulfa ☐
Tetracycline ☐
Other ☐
List _____

IF FEMALE, ARE YOU:
Taking birth control pills ☐
Pregnant ☐
Trying to conceive ☐
Presently in menopause ☐
Past menopause ☐

Is there anything else we should know about your medical history? _____

WHAT MEDICATIONS ARE YOU TAKING NOW?

Medication: _____ Condition: _____ How Long? _____
Medication: _____ Condition: _____ How Long? _____
Medication: _____ Condition: _____ How Long? _____
Medication: _____ Condition: _____ How Long? _____
Medication: _____ Condition: _____ How Long? _____

Date — Signature of Patient, Parent or Guardian — Reviewed By

Health History Updated — Signature of Patient, Parent or Guardian — Reviewed By

Health History Updated — Signature of Patient, Parent or Guardian — Reviewed By

HEIGHT _____
WEIGHT _____

GETTING TO KNOW YOU

What is your **estimate of your dental health?** ☐ **Good** ☐ **Fair** ☐ **Poor**
What specific dental concerns do you have now? _____

_____

_____

Please describe your long-term goals for your mouth and teeth: _____

_____

How long since your last dental visit? _____
What was done? _____
When was your last cleaning? _____
How frequently do you have your teeth professionally cleaned? _____
How often do you brush? _____ Floss? _____
Do you grind or clench your teeth? ☐ Yes ☐ No
If so, do you ☐ ***currently*** or have you ☐ ***previously*** worn a night guard?
Have you ever been treated for Gum Disease? ☐ Yes ☐ No
If so, when? _____
What was done? ☐ Deep cleaning ☐ Gum surgery ☐ Gum grafts
Which of the following dental services have you received?
☐ Extractions Reason: ☐ Decay/Broken Down ☐ Loose/Bone Loss
☐ Wisdom teeth ☐ Other: _____
☐ Root Canals _____
☐ Crowns or Caps _____
☐ Braces Start year: _____ Completion year: _____
☐ Implants _____
☐ Other: _____
Have you had problems or undesirable experiences with previous dental treatment? ☐ Yes ☐ No
What can we do to make you most comfortable? _____
Is there anything else you would like us to be aware of? _____

_____

Notations (for office use):