

# PATIENT HEALTH HISTORY

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
LAST FIRST

## DENTAL HISTORY

Reason for today's visit \_\_\_\_\_

General Dentist \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Treatment Performed \_\_\_\_\_

Please circle if you have any of the following:

Bad Breath	Grinding Teeth	Sensitivity to Heat
Bleeding Gum	Loose Teeth or Broken Fillings	Sensitivity to Sweets
Clicking or Popping Jaw	Periodontal Treatment	Sensitivity to Biting
Food Collection Between Teeth	Sensitivity to Cold	Sores or Growths

## MEDICAL HISTORY

Are you under a Doctor's care at this time? Y N If yes, please specify: Dr. Name \_\_\_\_\_  
Dr. Phone # \_\_\_\_\_

Do you premedicate before dental visits? Y N Do you have a latex allergy? Y N

Have you ever had a blood transfusion? Y N If yes, give the approximate date: \_\_\_\_\_

Have you ever had a surgical procedure? Y N Please list: \_\_\_\_\_

Are there any other health problems of which we should be advised? Please specify: \_\_\_\_\_

Please circle if you have any of the following:

AIDS	Emphysema	Pacemaker
Anemia	Epilepsy	Phen-fen
Angina	Fainting	Psychiatric Care
Arthritis	Glaucoma	Respiratory Disease
Artificial Heart Valve	Headaches	Rheumatic Fever
Artificial Joints	Heart Attack	Scarlet Fever
Asthma	Heart Murmur	Shortness of Breath
Back Problems	Heart Surgery	Sinus Trouble
Bleeding Problems	Hemophilia	Skin Rash
Blood Disease	Hepatitis	Stroke
Cancer	High Blood Pressure	Swelling of feet/ankles
Chemical Dependency	HIV Positive	Thyroid Problems
Chemo Therapy	Jaundice	TMD or TMJ
Circulatory Problems	Jaw Pain	Tobacco Habit
Cortisone Treatments	Kidney Disease	Tonsillitis
Cosmetic Surgery	Liver Problems	Tuberculosis
Coughing up Blood	Low Blood Pressure	Ulcer
Cough, persistent	Lung Disease	Venereal Disease
Diabetes	Mitral Valve Prolapse	Other _____
Dizzy Spells	Nervous Problems	

Please list any medications you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please circle if you have any allergic reactions to the following:

Anesthetics	Barbiturates	Iodine	Penicillin	Other _____
Aspirin	Codeine	Local Anesthetic	Sulfa	_____

***The above information is accurate and complete to the best of my knowledge. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to the performing of x-rays and oral examination. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.***

\_\_\_\_\_  
**Signature of Patient** (Parent if Patient is a minor)

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
Doctor's Signature upon review

\_\_\_\_\_  
Date