A MESSAGE ABOUT HEALTH HISTORIES AND DENTAL CARE: Although dentists primarily treat the mouth, head and neck areas, these areas all relate to your overall health. Therefore, it is important for us to know all facts relating to your present and past health. The information you give here is strictly confidential.

MEDICAL HEALTH HISTORY

Name of Physician (Medical Doctor) _____ Phone (_____) _____

Office Address _____ City _____ Zip Code _____

Date of your last **MEDICAL** examination: _____

	YES	NO
1. Are you now, or have you been under a physician's care during the past two years? ……..... If yes, what conditions were you treated for? _____	□	□
2. Have you ever had any major illnesses or operations…… ……..... Please list and give approximate dates: _____	□	□
3. Do you now take, or have taken, any kind of drugs or medicines during the past year? …… …… If yes, please list: _____	□	□
4. Have you experienced any adverse or allergic reaction to penicillin, local anesthetic, codeine or other drugs? ……..... If yes, please list and explain: _____	□	□
5. Are you currently, or have in the past used a Biphosphanate for osteoporosis? …… .	□	□

6. Please review the following carefully and check any conditions for which you have been treated:

	YES	NO		YES	NO		YES	NO
Heart condition or murmur	□	□	Tuberculosis	□	□	Hepatitis or liver disease	□	□
Rheumatic fever	□	□	Pneumonia	□	□	Venereal disease/STD's	□	□
Diabetes	□	□	Lung or respiratory disease	□	□	Fainting/dizziness/nervous	□	□
High or low blood pressure	□	□	Glaucoma/eye problem	□	□	Convulsions/seizures	□	□
Kidney disorder	□	□	Arthritis/joint problem	□	□	Psychological problems	□	□
Cancer or tumors	□	□	Endocrine (gland) disorder	□	□	Fever/cold/canker sores	□	□
Bleeding or blood disorder	□	□	Asthma or hay fever	□	□	AIDS or HIV positive	□	□
Anemia	□	□	Stroke	□	□	Ulcers	□	□

Please list any special problems or conditions not listed above:

	YES	NO
7. Women only: Are you pregnant? ……..	□	□

DENTAL HEALTH HISTORY

What is the reason for today's visit?_____

Name of previous dentist_____ Date last seen ___ _____

Why did you leave your last dentist?_____

What did you like most about any dentist you've ever seen? _____

	YES	NO
If there was a simple, inexpensive way to whiten your teeth, would you be interested? ……	□	□
Would you like to keep your natural teeth healthy and pain free for as long as possible? ……..	□	□
Does food catch between your teeth? ……... …… ……	□	□
Do your gums feel irritated or swollen, or do they bleed frequently when brushing? …….....	□	□
Have you ever been told that you have periodontal (gum) disease? ……. ……	□	□
Are any of your teeth sensitive to: □ hot, □ cold, □ sweets, or □ chewing pressure? …….....	□	□
Do you frequently clench or grind your teeth, or do your jaws or jaw muscles feel tired?.. …….... ……	□	□
Do you have frequent headaches or discomfort in your: □ ears, □ neck □ jaw or □ jaw joint?. . ……	□	□
Do you wear removable dentures (full or partial? …… ……..	□	□
Are you aware if you have any adverse oral habits (tongue thrusting, lip or nail biting, etc.) …….……..	□	□

How often do you: Brush? _____, floss? _____, go for regular cleanings and checkups? _____

Signature _____ Date _____

Patient (Parent or guardian for a minor child)