HEALTH HISTORY

PATIENT NAME: _____

Do you have or have you had any of the following?

- ☐ Angina
- ☐ Arteriosclerosis
- ☐ Artifical heart valves
- ☐ Atrial defibrillator
- ☐ Chest pain upon exertion
- ☐ Congenital heart defects
- ☐ Congestive heart failure
- ☐ Coronary artery disease
- ☐ Damaged heart valves
- ☐ Heart attack
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Mitral valve prolapse
- ☐ Pacemaker
- ☐ Rheumatic heart disease/ rheumatic fever
- ☐ Shunts
- ☐ Asthma
- ☐ Blood diseases
- ☐ Blood transfusion
- ☐ Bruise easily
- ☐ Excessive bleeding
- ☐ Hemophilia
- ☐ Leukemia
- ☐ Sickle cell disease
- ☐ Stroke
- ☐ Emphysema
- ☐ Respiratory disease
- ☐ Tuberculosis
- ☐ Hepatitis or Jaundice
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Radiation treatment
- ☐ Tumors or growths
- ☐ Cerebral Palsy
- ☐ Epilepsy or seizures
- ☐ Fainting spells
- ☐ Sleep apnea
- ☐ Arthritis
- ☐ Lupus
- ☐ Immume disorder
- ☐ Osteoporosis
- ☐ Allergies or hives
- ☐ Latex allergy
- ☐ AIDS Complex
- ☐ Artificial prosthesis
- ☐ Chicken Pox
- ☐ Difficulty swallowing
- ☐ Drug addition
- ☐ G.E. reflux/ persistant heartburn
- ☐ Glaucoma
- ☐ Mental disorder
- ☐ Scarlet fever
- ☐ Sinus trouble
- ☐ Tonsilitis
- ☐ Ulcers
- ☐ Venereal disease

DENTAL HISTORY

Reason for this visit _____

Chief Dental Complaint _____

Are you having pain at this time? ☐ YES ☐ NO

Date of last Dental Exam _____/_____/_____ Date of last teeth cleaning (prophylaxis) _____/_____/_____

Previous dentist _____ Date last treated _____/_____/_____

Any previous major dental treatment ☐ YES ☐ NO When _____

Are you interested in improving the appearance of your smile? ☐ YES ☐ NO

If so, what changes would you like to make? _____

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

- ☐ Teeth sensitive to cold, heat, sweet or pressure
- ☐ Bleeding Gums. How long? _____
- ☐ Food Impaction
- ☐ Clenching or grinding
- ☐ Burning of tongue
- ☐ Swelling or lumps in mouth
- ☐ Frequent blisters on lips or mouth
- ☐ Pain around ear
- ☐ Unusual sounds in ear while eating
- ☐ Bad breath
- ☐ Unpleasant taste
- ☐ Unfavorable dental experience
- ☐ Complications from extractions
- ☐ Periodontal treatment
- ☐ Orthodontic treatment
- ☐ Mouth Breathing
- ☐ Oral habits, i.e. fingernail biting, cheek biting, etc.
- ☐ Cigarettes, pipe or cigar smoking
- ☐ Texture of toothbrush _____
- ☐ Frequencey of brushing _____
- ☐ Dental Floss
- ☐ Inter dental stimulants
- ☐ Water jet device
- ☐ Disclosing tablets or solution
- ☐ Fluoide supplements
- ☐ Dry mouth
- ☐ Cold sores

Is there anything else about having dental treatment that bothers you? _____

_____

_____

_____