

Patient Health History

In order to help me render the proper dental service to you, would you please be kind enough to answer the following questions.

Thank you for your cooperation.

Print Name _____ Date _____

Best Phone # _____ Email _____

Please check box for "Yes"

- Are you having pain or discomfort at this time? _____
- Have you been hospitalized during the past 2 years? _____
- Have you had a physical exam within the past year? _____
- List all medications that you are taking at the present time: _____
- Are you allergic to (i.e, itching, rash, swelling of hands, feet, or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications including local anesthetics?
If yes, what: _____
- Have you ever had any excessive bleeding requiring special treatment?
- When you walk up stairs or take a walk, do you ever stop because of pain in your chest?
- Do your ankles swell during the day?
- Do you ever wake up from sleep short of breath?
- Have you ever been diagnosed with an eating disorder?
- Do you have any limitations due to a medical condition? _____
- Do you have any disease, condition, or problem not listed? _____
- WOMEN ONLY:** Are you pregnant now?
- WOMEN ONLY:** Do you anticipate becoming pregnant?

Circle any of the following which you have had or have at the present time:

HEART

Congestive heart failure
Congenital heart problems
Heart surgery
High/Low blood pressure
Heart pacemaker
Heart murmur (pre medicated?)
Stroke
Artificial heart valve
Rheumatic fever
Angina

HORMONES

Thyroid disease
Diabetes

LUNGS

Asthma
Tuberculosis
Emphysema

HEAD

Chronic sinus problem
Allergies or hives
Hay fever
Cold sores/fever blisters

INFECTIOUS DISEASE

H.I.V. or A.I.D.S
Sexually transmitted disease
Other infectious disease

LIVER

Liver disease
Hepatitis A,B,C
Yellow jaundice

BLEEDING DISORDERS

Hemophilia
Bruise easily
Sickle cell disease
Anemia
Blood transfusions

CANCER

CHEMOTHERAPY

KIDNEY DISEASE

X-RAY TREATMENT

Patient Health History

Please check box for "YES":

- Are you in pain today? _____
- Are you apprehensive about dental treatment?
- Have you had problems with previous dental treatment? _____
- Do you gag easily?
- Do you wear dentures?
- Does food catch between your teeth?
- Do you have difficulty in chewing your food?
- Do you chew on one side of your mouth?
- Do you avoid brushing any part of your mouth because of pain?
- Do your gums bleed easily?
- Do your gums bleed when you floss?
- Do your gums feel swollen or tender?
- Have you ever noticed slow healing sores in or around your mouth?
- Are your teeth sensitive?
- Do you feel twinges of pain when your teeth come in contact with:
 - Hot foods or liquids?
 - Cold foods or liquids?
 - Sour foods?
 - Sweet foods?
- Do you take fluoride supplements?
- Are you satisfied with the appearance of your teeth?
- Do you want complete dental care?
- How often do you brush? _____ How often do you floss? _____
- Does your jaw make noise so that it bothers you or others?
- Do you clench or grind your teeth?
- Do your jaws ever feel tired?
- Does your jaw get stuck so that you can not open freely?
- Does it hurt when you chew or open wide to take a bite?
- Do you have earaches or pain in front of the ears?
- Do you have any jaw symptoms or headaches upon waking in the morning?
- Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?
- Do you find jaw pain or discomfort extremely frustrating or depressing?
- Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?
- Do you have a temporomandibular disorder (TMD, TMJ)?
- Do you have pain in your face, cheeks, jaws, joints, throat, or temples?
- Are you aware of an uncomfortable bite?
- Have you had a blow to the jaw (trauma)?
- Are you a habitual gum chewer or pipe smoker?
- Do you take medication before dental procedures? If so please describe:

Date: _____ Signature of Patient: _____

Printed Name: _____