

# Medical Health History

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

Physician's Name \_\_\_\_\_ Date of Last Physical \_\_\_\_\_ Telephone # \_\_\_\_\_

Your estimate of overall health:  Excellent  Good  Fair  Poor

**Please check the box of any condition you have or may have had.**

		Allergies:	<input type="checkbox"/> None	
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Cephlasporins	<input type="checkbox"/> Chlorhexidine (CHX)	<input type="checkbox"/> Codeine
<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Fluoride	<input type="checkbox"/> Gluten	<input type="checkbox"/> Ibuprofen	<input type="checkbox"/> Latex/Rubber/Vinyl
<input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> Metals: (Nickel, Gold, Silver _____)		<input type="checkbox"/> Nuts / Fruit	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Sulfa	<input type="checkbox"/> Tetracycline	<input type="checkbox"/> Other _____		

## Health Issues:

<input type="checkbox"/> Abnormal Bleeding/Hemophilia	<input type="checkbox"/> Acid Reflux/GERD	<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Anemia/Sickle Cell
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Autoimmune Disorder	<input type="checkbox"/> Breathing/Sleep Problems <input type="checkbox"/> Cancer
<input type="checkbox"/> Chemo/Radiation	<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> Diabetes A1C _____	<input type="checkbox"/> Dizziness/Fainting <input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> Joint Replacement
<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Liver Problems/Hepatitis	<input type="checkbox"/> Mental Disorder	<input type="checkbox"/> Neurological Problems <input type="checkbox"/> Organ Transplant
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Respiratory Disease (COPD)	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcers

Explanation \_\_\_\_\_

Cardiovascular Disease *(if checked, please specify)*

<input type="checkbox"/> Angina	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Stroke	<input type="checkbox"/> Congenital Heart Defect
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Coronary Heart Disease	<input type="checkbox"/> Damaged Heart Valve	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> High or Low Blood Pressure	<input type="checkbox"/> Infective Endocarditis	<input type="checkbox"/> Mitral Valve Replacement	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Other _____				

Recent Surgeries \_\_\_\_\_

## Are You:

<input type="checkbox"/> Presently being treated for any other illness _____	<input type="checkbox"/> Experiencing frequent headaches _____
<input type="checkbox"/> Aware of a change in your health in the last 24 hours: <i>(i.e. fever, chills, new cough or diarrhea)</i> _____	<input type="checkbox"/> A smoker, previously smoked or use smokeless tobacco _____
<input type="checkbox"/> Taking medication for weight management _____	<input type="checkbox"/> Taking birth control pills _____
<input type="checkbox"/> Often exhausted or fatigued _____	<input type="checkbox"/> Currently pregnant _____
<input type="checkbox"/> Taking / Taken Bisphosphonates _____	<input type="checkbox"/> Nursing _____
	<input type="checkbox"/> Diagnosed with a prostate disorder _____

## Medications:

*List all medications, supplements and vitamins*

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Please make us aware of changes to your health history.**

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_

# Dental History Form

**Patient Name** \_\_\_\_\_ Age \_\_\_\_\_

Referred by \_\_\_\_\_ Previous Dentist's name \_\_\_\_\_ How long? \_\_\_\_\_

Date of most recent dental exam \_\_\_\_ / \_\_\_\_ / \_\_\_\_ I see my Dentist (circle): 3 m, 6 m, 12m, other, not routinely

**What is your immediate concern?** \_\_\_\_\_

On a scale of 1-10 (10 greatest), how important is your dental health? 1 2 3 4 5 6 7 8 9 10

On a scale of 1-10 (10 greatest), how would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

On a scale of 1-10 (10 greatest), how fearful are you of dental treatment? 1 2 3 4 5 6 7 8 9 10

<b>Personal History</b>	<b>Yes</b>	<b>No</b>
1. Have you had an unfavorable dental experience?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever had complications from past dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had trouble getting numb or had any reactions to local anesthesia?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have, or have you had any teeth removed or teeth that never developed?	<input type="checkbox"/>	<input type="checkbox"/>
5. Did you ever have orthodontic treatment, braces, or your bite adjusted?	<input type="checkbox"/>	<input type="checkbox"/>

<b>Gum/Bone History - Periodontal</b>	<b>Yes</b>	<b>No</b>
6. Do your gums bleed or do they hurt during brushing/flossing?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever been told you have gum disease or are losing bone around your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever noticed an unpleasant taste/smell in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
9. Does anyone in your family have a history of periodontal/gum disease?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you experienced gum recession (teeth look longer)?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever had any teeth become loose on their own?	<input type="checkbox"/>	<input type="checkbox"/>

<b>Tooth Structure History - Cavities</b>	<b>Yes</b>	<b>No</b>
12. Have you had any cavities within the past 3 years?	<input type="checkbox"/>	<input type="checkbox"/>
13. Does the amount of your saliva in your mouth seem to little or do you have trouble eating/swallowing food?	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you feel or notice any holes on the tops of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
15. Are your teeth sensitive to hot, cold, biting, sweets, etc or do you avoid brushing any area?	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you have grooves or notches on your teeth near the gum line?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever broken, chipped, cracked any teeth or had a toothache?	<input type="checkbox"/>	<input type="checkbox"/>
18. Do you get food caught between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>

<b>Occlusion History - Bite, Jaw &amp; TMJ</b>	<b>Yes</b>	<b>No</b>
19. Do you have problems with your jaw joint? (pain, popping, cracking, locking, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
20. Do you avoid chewing gum, carrots, nuts, hard or chewy foods?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	<input type="checkbox"/>	<input type="checkbox"/>
22. Are your teeth becoming more crooked, crowded, or overlapped?	<input type="checkbox"/>	<input type="checkbox"/>
23. Are your teeth developing spaces or becoming loose?	<input type="checkbox"/>	<input type="checkbox"/>
24. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together?	<input type="checkbox"/>	<input type="checkbox"/>
25. Do you clench your teeth during the day or night or wake with a headache?	<input type="checkbox"/>	<input type="checkbox"/>
26. Do you wear, or have you ever worn, a bite appliance?	<input type="checkbox"/>	<input type="checkbox"/>

<b>Cosmetic History - Smile</b>	<b>Yes</b>	<b>No</b>
27. Is there anything about your appearance of your teeth that you would like to change?	<input type="checkbox"/>	<input type="checkbox"/>
28. Have you ever whitened/bleached your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
29. Have you felt uncomfortable or self-conscious about the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
30. Have you been disappointed with the appearance of previous dental work?	<input type="checkbox"/>	<input type="checkbox"/>