Health Information

Patient Name: ______________________ DOB: ______________

Have you ever had any of the following? (Please check those that apply):

- ☐ Abuse - Drugs or Alcohol
- ☐ Exposed to AIDS Virus
- ☐ Acid Reflux
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
  - Premed Required? ____
- ☐ Asthma
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes
  - ☐ Type I
  - ☐ Type II
- ☐ Dizziness/Fainting
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Gastric Bypass
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
  - Date: __________
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis: A, B, or C
- ☐ High Blood Pressure
- ☐ Jaw Injury
  - Date: __________
- ☐ Kidney Disease/Dialysis
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Myeloma
- ☐ Nervous Disorders
- ☐ Pacemaker.
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Disease
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Issues
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Aspirin Allergy
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Latex Allergy
- ☐ Metal Allergy
- ☐ **Herbal medicines and dietary supplements, What?** ______________
- ☐ **Other:** ______________

- Are you now under the care of a physician?
  If yes, please explain: ______________________________
- Name of Physician: ______________________________
  Phone: ______________________________
- Have you been admitted to a hospital or needed emergency care during the past two years?
  If yes, please explain: ______________________________
- Are you taking any medication? (Please List) ______________________________
- List any surgeries you had including dates: ______________________________
- Do you have any health problems that need further clarification?
  If yes, please explain: ______________________________
- Are you pregnant? Due Date: ______________________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

______________________________ Date: ______________

Signature of Patient, Parent, or Guardian

Dental History

Patient Name: ______________________ DOB: ______________

Last dental Visit: ______________________ Were x-rays taken? ________

What was done? ______________________

____

Was any suggested work left incomplete? ______________________

____

Yes	No	
☐	☐	Any pain in or near ears?
☐	☐	Any pain when opening or closing your mouth?
☐	☐	Allergies to dental anesthetics (novocaine)?
☐	☐	Do you prefer dental anesthetics while having necessary work done?
☐	☐	Have your wisdom teeth been removed?
☐	☐	Do your gums bleed? How often do you brush? ____________ Floss? ________
☐	☐	Do you clench or grind your teeth?
☐	☐	Any part of your mouth sore to pressure or irritants (cold, sweets, etc)? If so, can you locate? ______________________
☐	☐	Would you ever consider orthodontics as an adult?
☐	☐	Have you ever had periodontal or "gum" surgery or treatments?
☐	☐	Have you ever been told you should have periodontal treatment?
☐	☐	Do you require pre medication prior to dental treatment or cleaning
☐	☐	Do you smoke? How much?
☐	☐	Would you like info on how to quit?

- How do you feel about your teeth? ______________________

  ____
- What would you change? ______________________

  ____
- Have you had an unpleasant dental experience? Please describe: ______________________

  ____
- OPTIONAL: To help us make your dental experience more enjoyable, we would appreciate knowing why you left your previous dentist: ______________________

  ____
- Whom may we thank for referring you? ______________________

  ____

CERTIFICATION: I certify that the answers are correct to the best of my knowledge.

______________________ Date: ______________

Signature of Patient