NAME____DATE____________________________

MEDICAL HEALTH HISTORY

Do You Have or Have You Had Any of the Following? ***Check Any That Apply***

- ❑ **HEART PROBLEMS**
  - ❑ Heart Attack - Date______________________
  - ❑ Chest Pain /Shortness of Breath
  - ❑ Blood Pressure Problems
  - ❑ Heart Murmur
  - ❑ Taking Heart Medications
  - ❑ Rheumatic Fever
  - ❑ Pacemaker
  - ❑ Artificial Heart Valve – Date________________
- ❑ **BLOOD PROBLEMS**
  - ❑ Stroke – Date____________________________
  - ❑ Frequent Nose Bleeds
  - ❑ Abnormal Bleeding
  - ❑ Blood Disease (anemia)
  - ❑ Had a blood transfusion - Date_______________
- ❑ **ALLERGY PROBLEMS**
  - ❑ Hay Fever
  - ❑ Sinus Problems
  - ❑ Taking Allergy Medication
  - ❑ Asthma
- ❑ **INTESTINAL PROBLEMS**
  - ❑ Ulcers
  - ❑ Unexplained Weight Gain or Loss
  - ❑ Special Diet/Eating Disorder
  - ❑ Kidney or Bladder Problems
- ❑ **BONE/JOINTS/IMPLANTS**
  - ❑ Arthritis
  - ❑ Taking Osteoporosis Medication (i.e. Fosamax, etc.)
  - ❑ Back or Neck Pain
  - ❑ Joint replacement
    Joint & Date__________________________
  - ❑ Surgical Implants (i.e. hip, knee, breast, etc.)
- ❑ **DIABETIC**
  - ❑ Thirsty or dry mouth much of the time
  - ❑ Family History of Diabetes – Who____________
  - ❑ Diabetes Type___________________________
  - ❑ Your Last A1C and #?____________________

❑ Previously taken premedication for dental appointments?
PREMED ___________________________________

- ❑ **HISTORY OF HEAD INJURY**
  - ❑ Fainting Spells, Seizures or Epilepsy
    Last Episode - _____________________________
  - ❑ Frequent or Severe Headaches
- ❑ **AUTOIMMUNE DISEASE**
  - ❑ Crohns, Lupus, Fibromyalgia, Sjogrens
    Other____________________________________
- ❑ **OTHER CONDITIONS**
  - ❑ Tuberculosis or Other Respiratory Disease
  - ❑ Cancer/Tumor – Date_________________________
    Type / Treatment____________________________
  - ❑ Head & Neck Radiation
  - ❑ Thyroid Problems
  - ❑ Persistent Cough or Swollen Glands
  - ❑ A Smoker __________pk/day
  - ❑ Hepatitis, Jaundice or Liver Trouble
  - ❑ History of Alcohol or Drug Abuse
  - ❑ Sexually Transmitted Disease
  - ❑ HIV-positive/AIDS
  - ❑ Glaucoma
  - ❑ Do you Wear Contact Lenses
  - ❑ Have You Ever Taken the Appetite Suppressants Redux, Fen-Phen, or Redux-Phen
  - ❑ Any Disease, Condition or Problems not listed here that you feel we should know about. If so, please describe:_____________________________________

ANY UNUSUAL REACTION TO:

- ❑ Local Anesthetics
- ❑ Penicillin
- ❑ Other Antibiotics___________________________
- ❑ Aspirin, Tylenol or Ibuprofen, Codeine, Demerol or other Narcotics (Circle)
- ❑ Metals_____________________________________
- ❑ Latex or Rubber Dam
- ❑ Other______________________________________

WOMEN ONLY:
Are you taking contraceptives or other hormones?_______________________________
Are you pregnant or think you may be?______________
Are you nursing?_________________________________

Patient (Guardian)**Signature**___________________________

Dentist Signature_____________________________________

Dental Health History

- ◻ Are you dissatisfied with the appearance of your teeth?
- ◻ Are you unhappy with the color?
- ◻ Do you have difficulty chewing your food?
- ◻ Are your teeth sensitive to cold or hot?
- ◻ Have you had problems with previous dental treatment?
- ◻ Do you prefer to save your teeth?
- ◻ Are you concerned with bad breath?
- ◻ Do you gag easily?
- ◻ Sore or Bleeding gums?
- ◻ Injury to face or jaw?
- ◻ Clench or grind your teeth?
- ◻ Sore or popping jaw joints?
- ◻ Previous orthodontic treatment?
- ◻ Has your jaw been locked before?
- ◻ Frequent cold sores?
- ◻ Are you concerned about snoring?