Health History

Patient Name: ______________________ **Birth Date:** ______________________

Have your past dental experiences been satisfactory? ______________________

How do you feel about the appearance of your teeth? ______________________

Do you have or have you had any of the following? (please check all that apply to you)

- Bleeding gums
- Broken fillings
- Chronic bad breath
- Decayed teeth
- Food catches between teeth
- Grinding or clenching of teeth
- Injury to teeth or jaw
- Loose teeth
- Orthodontic treatment
- Periodontal treatment
- Painful or locking jaw
- Sensitivity to sweet, hot, cold, biting
- Sores, growths or swelling in mouth

Do you have or have you had any of the following? (please check all that apply to you)

- AIDS/ HIV Positive
- Anemia
- Arthritis, Rheumatism
- Artificial Heart Valve
- Artificial Joints
- Asthma, Sinus Problems
- Autoimmune Disease
- Back Problems
- Blood Disease
- Abnormal Bleeding, Prolonged Healing, Bruising
- Bypass
- Cancer
- Chemical Dependency
- Chemotherapy
- Chest Pains
- Circulatory Problems
- Congestive Heart Failure
- Cortisone Treatments/Steroids
- Cough, Persistent/Chronic
- Cough up Blood
- Dementia
- Diabetes
- Epilepsy/Seizures
- Fainting
- Glaucoma/Eye Disorders
- Headaches, Migraines
- Heart Murmur
- Heart Disease (describe)
- Hemophilia
- Hepatitis/Liver Diseases/Jaundice
- High Blood Pressure
- High Cholesterol
- Kidney Disease
- Low Blood Pressure
- Mitral Value Prolapse
- Malignancy or Tumor/Cyst
- Nervous Disorders
- Pacemaker
- Psychiatric Care
- Radiation Treatment
- Respiratory Disease
- Rheumatic Fever/ Rheumatic Heart Disease
- Scarlet Fever
- Shortness of Breath
- Sickle cell Disease/Trait
- Skin Rash/Hives
- Swelling Feet/Ankles
- Stroke
- Thyroid Disease
- Tobacco Use
- (past)
- Tobacco Use
- (present)
- Tuberculosis
- Ulcer/Digestive Disorders
- Venereal Disease

Physician: ______________________ **Phone #:** ______________________

Date of last physical exam: ______________ **Are you currently under a physician's care?** ______________

If so, please explain: ______________________

Please list all medications you are currently taking: ______________________

Allergies/reactions to medications, or other allergies: ______________________

Please describe any impending operations or recent injuries: ______________________

Women only: Are you pregnant? __________**Nursing?** __________ **Taking birth control pills?** __________

Patient Signature: ______________________**Date:** ______________________