CHART NUMBER_____

INTERNAL USE ONLY

HEALTH HISTORY

PATIENT NAME: _____ BIRTH DATE: _____

EMERGENCY CONTACT NAME _____RELATIONSHIP_____PHONE_____

PHYSICIAN NAME _____ ADDRESS _____ PHONE _____

I. CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand question)

1. YES NO IS YOUR GENERAL HEALTH GOOD?
2. YES NO HAS THERE BEEN A CHANGE IN YOUR HEALTH WITHIN THE LAST YEAR?
3. YES NO HAVE YOU BEEN HOSPITALIZED OR HAD A SERIOUS ILLNESS IN THE LAST THREE YEARS?
   IF YES, WHY? _____
4. YES NO ARE YOU BEING TREATED BY A PHYSICIAN NOW? FOR WHAT? _____
   DATE OF LAST MEDICAL EXAM? _____

II. HAVE YOU EXPERIENCED:

5.	YES	NO	CHEST PAIN (ANGINA)?	16.	YES	NO	DIZZINESS?
6.	YES	NO	SWOLLEN ANKLES?	17.	YES	NO	RINGING IN EARS?
7.	YES	NO	SHORTNESS OF BREATH?	18.	YES	NO	HEADACHES?
8.	YES	NO	RECENT WEIGHT LOSS, FEVER, NIGHT SWEATS?	19.	YES	NO	FAINTING SPELLS?
9.	YES	NO	PERSISTENT COUGH, COUGHING UP BLOOD?	20.	YES	NO	BLURRED VISION?
10.	YES	NO	BLEEDING PROBLEMS, BRUISING EASILY?	21.	YES	NO	SEIZURES?
11.	YES	NO	SINUS PROBLEMS?	22.	YES	NO	EXCESSIVE THIRST?
12.	YES	NO	DIFFICULTY SWALLOWING?	23.	YES	NO	FREQUENT URINATION?
13.	YES	NO	DIARRHEA, CONSTIPATION, BLOOD IN STOOLS?	24.	YES	NO	DRY MOUTH?
14.	YES	NO	FREQUENT VOMITING, NAUSEA?	25.	YES	NO	JAUNDICE?
15.	YES	NO	DIFFICULTY URINATING, BLOOD IN URINE?	26.	YES	NO	JOINT PAIN, STIFFNESS?

III. DO YOU HAVE OR HAVE YOU HAD:

27.	YES	NO	HEART DISEASE?	38.	YES	NO	AIDS/HIV?
28.	YES	NO	HEART ATTACK, HEART DEFECTS? IF YES, WHEN_____	39.	YES	NO	TUMORS, CANCER?
29.	YES	NO	HEART MURMURS?	40.	YES	NO	ARTHRITIS?
30.	YES	NO	RHEUMATIC OR SCARLET FEVER?	41.	YES	NO	EYE DISEASES?
31.	YES	NO	STROKE, HARDENING OF ARTERIES?	42.	YES	NO	SKIN DISEASES?
32.	YES	NO	HIGH BLOOD PRESSURE?	43.	YES	NO	ANEMIA?
33.	YES	NO	ASTHMA, TB, EMPHYSEMA, LUNG DISEASES?	44.	YES	NO	SYPHILIS/GONORRHEA?
34.	YES	NO	HEPATITIS, OTHER LIVER DISEASE?	45.	YES	NO	HERPES?
35.	YES	NO	STOMACH PROBLEMS, ULCERS?	46.	YES	NO	KIDNEY DISEASE?
36.	YES	NO	ALLERGIES TO**: drugs, foods, medications, latex?**	47.	YES	NO	THYROID DISEASE?
37.	YES	NO	FAMILY HISTORY: diabetes, heart problems, tumors?	48.	YES	NO	DIABETES?

IV. DO YOU HAVE OR HAVE YOU HAD:

49.	YES	NO	PSYCHIATRIC CARE?	54.	YES	NO	HOSPITALIZATION?
50.	YES	NO	RADIATION TREATMENTS?	55.	YES	NO	BLOOD TRANSFUSIONS?
51.	YES	NO	CHEMOTHERAPY?	56.	YES	NO	SURGERIES?
52.	YES	NO	PROSTHETIC HEART VALVE?	57.	YES	NO	PACEMAKER?
53.	YES	NO	ARTIFICIAL JOINT?	58.	YES	NO	CONTACT LENSES?

V. ARE YOU TAKING:

59. YES NO RECREATIONAL DRUGS?
60. YES NO DRUGS, MEDICATIONS, OVER-THE-COUNTER MEDICINES (INCLUDING ASPIRIN), NATURAL REMEDIES?

PLEASE LIST: _____

VI. WOMEN ONLY:

61.	YES	NO	ARE YOU OR COULD YOU BE PREGNANT?	63.	YES	NO	ARE YOU NURSING?
62.	YES	NO	TAKING BIRTH CONTROL PILLS?				

VII. ALL PATIENTS:

64. YES NO DO YOU HAVE OR HAVE YOU HAD ANY OTHER DISEASES OR MEDICAL PROBLEMS NOT LISTED ON THIS FORM?
    IF YES, PLEASE EXPLAIN: _____
65. YES NO ARE YOU TAKING MEDICATION (BISPHOSPHONATES) FOR TREATMENT OF OSTEOPOROSIS?
IF SO, PLEASE LIST:
_____

66. YES NO HAVE YOU HAD AN ORGAN OR TISSUE TRANSPLANT?
IF YES, PLEASE EXPLAIN: _____

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67. YES NO HAVE YOU OR ANYONE IN YOUR FAMILY HAD DIFFICULTY WITH GENERAL ANESTHESIA?
IF YES, PLEASE EXPLAIN: _____
68. YES NO DO YOU SNORE WHILE SLEEPING OR HAVE YOU BEEN DIAGNOSED WITH SLEEP APNEA?
69. YES NO DO YOU SMOKE? HOW OFTEN? _____ AMOUNT _____
70. YES NO DO YOU CONSUME ALCOHOL? HOW OFTEN_____ AMOUNT _____

Dental History

I. ALL PATIENTS PLEASE ANSWER THE FOLLOWING:

1. DATE OF LAST DENTAL VISIT _____ NAME OF PREVIOUS DENTIST OR PRACTICE _____
2. DATE OF LAST DENTAL XRAYS, IF KNOWN _____
3. WHAT IS THE REASON FOR TODAYS VISIT? (CHIEF COMPLAINT) _____
4. YES NO ARE YOU HAVING ANY DISCOMFORT AT THIS TIME?
IF SO, WHAT IS THE DISCOMFORT? _____
5. YES NO DO YOU HAVE CONCERNS ABOUT PREVIOUS DENTAL CARE OR THIS DENTAL VISIT?
PLEASE EXPLAIN _____
6. YES NO DO YOUR GUMS BLEED?
IF SO, WHEN DO THEY BLEED? _____
7. YES NO ARE YOUR TEETH SENSITIVE TO COLD?
8. YES NO ARE YOUR TEETH SENSITIVE TO HOT?
9. YES NO ARE YOUR TEETH SENSITIVE TO SWEETS?
10. YES NO ARE YOUR TEETH SENSITIVE TO BITING OR CHEWING PRESSURE?
11. YES NO DOES FOOD WEDGE BETWEEN YOUR TEETH?
12. HOW MANY TIMES DO YOU BRUSH YOUR TEETH DAILY? □0 □1 □2 □3 □MORE THAN 3
13. YES NO DO YOU USE DENTAL FLOSS?
14. YES NO DO YOU USE A WATER JET TO CLEAN YOUR TEETH?
15. WHAT WOULD YOU LIKE TO CHANGE ABOUT THE PRESENT CONDITION OF YOUR MOUTH OR SMILE?
_____

II. ADULT PATIENTS (AGE 14 AND ABOVE) PLEASE ANSWER THE FOLLOWING:

16. YES NO ARE YOUR TEETH LOOSE?
17. YES NO HAVE YOU EVER BEEN TOLD YOU HAVE GUM DISEASE?
18. YES NO HAVE YOU EVER HAD GUM TREATMENT?
IF SO, WHEN _____
19. YES NO ARE YOU AWARE OF ANY SWELLING OR LUMP IN YOUR MOUTH?
20. YES NO AT TIMES, DO YOU FEEL YOU HAVE BAD BREATH?
21. YES NO AT TIMES, DO YOU NOTICE A BAD TASTE IN YOUR MOUTH?
22. YES NO DO YOU CLENCH OR GRIND YOUR TEETH?
23. YES NO DO YOU HAVE ANY PAIN IN OR AROUND YOUR EARS?
24. YES NO DO YOU HEAR POPPING, CLICKING, OR SNAPPING NOISES WHEN YOU CHEW?
25. YES NO ARE YOU WEARING ANY ORAL OR FACIAL PIERCING? WHERE? _____

II. PATIENTS AGE 13 AND UNDER PLEASE ANSWER THE FOLLOWING:

26. DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS?
27. YES NO THUMBSUCKING
28. YES NO FINGER SUCKING
29. YES NO CURRENT USE OF A PACIFIER

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my medical history, dental history and/or medication.

Person completing medical and dental history: _____
Relationship to patient: _____
Signature: _____
Medical and Dental History Reviewed:
Doctor: _____ Date: _____

RECALL REVIEW:

1. Patient signature _____ Doctor signature _____ Date _____
2. Patient signature _____ Doctor signature _____ Date _____
3. Patient signature _____ Doctor signature _____ Date _____
4. Patient signature _____ Doctor signature _____ Date _____
5. Patient signature _____ Doctor signature _____ Date _____