CONFIDENTIAL HEALTH HISTORY

(PLEASE UPDATE **CHANGES** TO YOUR HEALTH AND MEDICATIONS AT BOTTOM OF PAGE)

- Please list all known **ALLERGIES:** Penicillin, Sulfa, Aspirin, Local anesthetics, Latex, Other?

  _____

- Please list all **MEDICATIONS** that you are currently taking and the reason for each.

  _____

  _____

- Are you under a **PHYSICIAN'S CARE** now? ____If yes, why? _____
- Do you use **TOBACCO**? NO_____ YES_____ If yes, what form? _____
- Please list any surgeries or illnesses you have had in the past year? _____
- Have you ever been hospitalized or had a major operation in the past year? _____If so, why? _____
- Have you taken **BISPHOSPHONATES** for Osteoporosis or Cancer treatment? (Like Boniva, Fosamax, Actonel or Zometa)

  _____

- For Women: Are you pregnant or nursing? _____What is your Due Date? _____
- Are you taking birth control? _____What Kind? _____

Please Circle and **date** if you have or have had any of the following:

- Heart surgery
- Artificial heart valve
- Heart attack
- Infective endocarditis
- Congestive heart failure
- Mitral valve prolapse
- High blood pressure
- Pacemaker
- Chest pain--Angina
- Epilepsy--Seizures
- Stroke
- Hepatitis type a, b, c
- Artificial joints
- Breathing problems
- Asthma
- Cancer, type_____
- Radiation
- Chemotherapy
- Abnormal bleeding with surgery
- AIDS/HIV
- Anemia
- Arthritis, Rheumatism
- Back problems
- Chemical dependency
- Circulatory problems
- Cough, persistent
- Acid Reflux, GERD
- Diabetes
- Eating Disorder
- Emphysema
- Respiratory disease
- Fainting or Dizziness
- Glaucoma
- Headaches
- Herpes
- Cold sores, fever blister
- Kidney disease
- Liver disease
- Hearing loss
- Nervous problems
- Psychiatric care
- Depression
- Sinus trouble
- Thyroid problems
- Tuberculosis
- Ulcers
- Unexplained weight loss
- Unexpected weight gain
- Other_____

I understand that it is my responsibility to inform the dental office of any changes in medical status and that providing incorrect information can be dangerous to my (or patient's) health. To the best of my knowledge this information is accurate.

Signature of Patient, parent or guardian: _____DATE: _____

Date:	**Please Update Changes (medications, illnesses, and surgeries)**	**Signature**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Patient Name _____ **Birth Date** _____ **Todays Date**_____

Mailing Address _____

Home phone _____ **Cell phone** _____ **Work Phone** _____

Email Address _____

Emergency Contact _____ **Phone:** _____ **Relationship**_____

Physicians Name: _____ **Phone:**_____ **Address**_____

CONFIDENTIAL DENTAL HISTORY

- What is the purpose of your initial visit? _____
- When was your last dental check-up? _____
- When were your last dental x-rays taken? _____
- How often do you brush your teeth? _____
- Do you get food stuck in your teeth or gums when you eat? No_____ Yes_____
- How often do you floss or use interdental picks? _____
- Do you have problems chewing or swallowing? _____
- If you have sensitive teeth, to what? (Hot, cold, sweets, chewing, aching on its own, wakes you up at night)_____
- Are you aware of clenching or grinding your teeth? _____
- Do you experience pain or soreness in the jaw joints or facial muscles? _____
- Have you been diagnosed with or treated for periodontal (gum) disease? _____ When? _____
- Do you have dry mouth? _____
- Do you get mouth sores? How often? _____
- Are you pleased with the appearance of your teeth? _____
- How frequently do you drink soda, sports drinks or juice? _____
- Do your gums bleed when brushing or flossing? _____
- Have you had orthodontic treatment, braces? _____
- Any comments regarding previous dental experience? _____
- Do you have any other dental concerns or problems? _____