# *HEALTH HISTORY* Patient Name_____ Date of Birth_____

Physician's Name_____ Phone Number _____

List any hospitalizations for surgery or serious illness:

_____

List any medications (including non-prescription):

_____

| ***ARE YOU ALLERGIC or have you had reactions to*:** | YES | NO |
|---|---|---|
| Local anesthetics (e.g. Novacaine)…… | O | O |
| Penicillin or other antibiotics…… | O | O |
| Sulfa drugs…… | O | O |
| Barbiturates, sedatives or sleeping pills…… | O | O |
| Aspirin…… | O | O |
| Iodine…… | O | O |
| Any metals (nickel, mercury, etc.)…… | O | O |
| Latex/rubber…… | O | O |
| Other (please list)_____ | | |

| | | |
|---|---|---|
| Have you ever taken Fen-Phen/Redux…… | O | O |
| Do you use tobacco…… | O | O |
| Do you use controlled substances…… | O | O |
| Do you have persistent cough/throat clearing lasting more than 3 weeks not associated with a known illness…… | O | O |
| Any other conditions/problems that you think we should know about…… | O | O |
| ****for women only**** | | |
| Are you pregnant or think you may be…… | O | O |
| Are you nursing…… | O | O |
| Are you taking birth control pills…… | O | O |

| ***DENTAL HISTORY*** | | |
|---|---|---|
| Do you get cold sores/fever blisters…… | O | O |
| Do your gums bleed with brushing/flossing… | O | O |
| Are your teeth sensitive to hot/cold…… | O | O |
| Are your teeth sensitive to sweet/sour…… | O | O |
| Do you have sores/lumps in or near mouth… | O | O |
| Have you had head/neck/jaw injuries…… | O | O |
| Have you noticed teeth loosening…… | O | O |
| Have you ever had difficult extractions…… | O | O |
| Have you ever had prolonged bleeding after extractions…… | O | O |

Reason for this visit_____

When was your last visit_____

What was done then_____

Previous dentist name/location_____

_____

How often do you brush your teeth_____

How often do you floss your teeth_____

| ***DO YOU HAVE or have you ever had:*** | YES | NO |
|---|---|---|
| Abnormal bleeding…… | O | O |
| Bruising easily…… | O | O |
| Rheumatic heart disease…… | O | O |
| Rheumatic/scarlet fever…… | O | O |
| Heart defect/murmur…… | O | O |
| Heart trouble/attack or angina …… | O | O |
| Chest pain…… | O | O |
| Congenital heart problem…… | O | O |
| Mitral valve prolapse…… | O | O |
| Heart surgery…… | O | O |
| Pacemaker…… | O | O |
| Shortness of breath…… | O | O |
| High/low blood pressure…… | O | O |
| Swelling of feet/ankles/hands…… | O | O |
| Hepatitis/jaundice/liver disease…… | O | O |
| Stroke…… | O | O |
| Frequent sinus infections…… | O | O |
| Lung/breathing problems (e.g. COPD) | O | O |
| Asthma…… | O | O |
| Seasonal allergies…… | O | O |
| Tuberculosis/cough with blood…… | O | O |
| Diabetes…… | O | O |
| AIDS/HIV…… | O | O |
| Thyroid problems…… | O | O |
| Joint replacement or implant…… | O | O |
| Stomach ulcer…… | O | O |
| Kidney trouble…… | O | O |
| Chemotherapy (cancer/leukemia)…. | O | O |
| Sexually transmitted disease…… | O | O |
| Epilepsy/seizures…… | O | O |
| Glaucoma…… | O | O |
| Tonsillitis …… | O | O |
| Tumors …… | O | O |
| Nervousness…… | O | O |
| Mental health care…… | O | O |
| Chemical dependency…… | O | O |
| Eating disorders…… | O | O |
| Back problems…… | O | O |
| Cortisone treatment…… | O | O |

*I certify that the above information is accurate to the best of my knowledge. I understand providing incorrect information can be dangerous to my health.*

Patient Signature_____

Date_____

Doctor Signature_____