Health History

Patient's Name _____ Date of Birth _____

Medical Information

Name of Physician: _____ Ph#: _____

Have you had any serious illness, operation or been hopitalized in the past 5 years? YES / NO

If yes, please explain: _____

Has a Physician recommended that you take antibiotics prior to your dental appointment? YES / NO

If yes, please explain: _____

Please list any medications (over the counter and prescription) that you are currently taking: _____

WOMEN (Please check all that apply) □Pregnant □Nursing □Taking Oral Contraceptives

Are you ***ALLERGIC*** to any of the following (Please check all that apply)

□ ASPIRIN □ PENICILLIN □ CODEINE □ ACRYLIC □ LATEX Other: _____

Do you now have or have you ever had any of the following? Do you take any of these medications?

Please check all that apply:

Y	N		Y	N		Y	N	
□	□	Artificial Heart Valve	□	□	Tuberculosis	□	□	Epilepsy or Seizures
□	□	Congenital Heart Defects	□	□	Asthma	□	□	Cold Sores/Fever Blisters
□	□	Mitral Valve Prolapse	□	□	Sinus Trouble	□	□	Shingles
□	□	Heart Murmur	□	□	Cancer	□	□	Alzheimer's Disease
□	□	Heart Attack/Stroke	□	□	Liver Disease	□	□	Psychiatric Care
□	□	Rheumatic Fever	□	□	Hepatitis (cicle one) A B C	□	□	Drug Addiction
□	□	Blood Disorder	□	□	Stomach/Intestinal Disease	□	□	Osteoporosis
□	□	AIDS/HIV Positive	□	□	Kidney Problems	□	□	Bisphosphonate Treatment
□	□	High Blood Pressure	□	□	Thyroid Disease	□		(Fosamax, Actonel, Boniva
□	□	Excessive Bleeding	□	□	Artifical Joint	□		Reclast, Aredia, Zometa)
□	□	Diabetes	□	□	Pain in Jaw Joints			Other: _____
□	□	Hypoglycemia	□	□	Frequent Headaches			
□	□	Lung Disease	□	□	Fainting Spells/Dizziness			

When a health care worker is exposed to my blood or body fluids through a needle stick, cut or splash to the eye or mouth, I agree to have my blood tested for blood-borne disease to include AIDS/HIV, Hepatitis B and C. Initial: _____

Dental Questionnaire

On a scale of 1 to 5 (1 being the lowest and 5 the highest) please rate:

How do you feel your overall dental health is? 1 2 3 4 5

What is your level of sensitivity/anxiety to dental procedures? 1 2 3 4 5

How do you feel about your smile and the look of your teeth? 1 2 3 4 5

When was your last hygiene visit? (MM/YYY) _____

What is the main reason for your visit today?

□ Tooth pain □ whitening
□ check up □sedation dentistry
□ cleaning □ cosmetic dentistry
□ braces

I would like to learn more about:

□ braces □ sedation □ veneers
□ whitening □ implants □ dentures
□ cosmetic dentistry □ bridges □ TMJ/Jaw pain

The information I have given is true and accurate to the best of my knowledge

Patient Signature _____ Date _____

Doctor Signature Date