Patient Health History

Today's Date: ________________________

Patient's Name: (Mr., Mrs., Ms.) ____________________________________ Date of Birth: __________ Age: ________
Residence Address: ______________________ City: ____________ Zip: ___________ How Long? __________
Home Phone _______________ Work Phone _________________ Cell Phone ____________ Emergency # ____________
Previous Address __________________________________ City ______________ State ____________ Zip ____________
Occupation ________________ Employer _________________ How Long? _______________ HR Dept # ___________
Business Address __________________________________ City ________________ Zip _____________
Spouses Name _______________ Spouses Occupation ____________ Employer _______________ Work # ____________
Spouses Business Address ________________________________ City ______________ State ______ Zip ______________
Do you have Dental Insurance? Yes / No Does your Spouse have Dental Insurance? Yes / No
Social Security # Mr. _______________________ Social Security # Mrs. ___________________________
Drivers License # Mr. ____________________ Exp Date: ____________ State Issued ____________
Drivers License # Mrs, ____________________ Exp Date: __________ State Issued ____________
Person Financially Responsible (other than yourself) __________________________ Relation _______________________
Bank Reference (Name/Branch/City/Zip) ____ Phone# ___________________
Name of Person Not Living with You ____________________________ Phone __________________ Relation ____________
Person to Contact in the event of an emergency ____________________________ Phone ______________ Relation _________
Do you have Children? Yes /No Names and Ages: _________________ ____________________ _____________________

Name of Previous Dentist _____________________ **Last Visit** ________________ **What for?** ______________________________
Address ____________________________ **City** _______________ **State** ________ **Zip** __________ **Phone#** ____________________
Name of Physician (MD) _____________________________ **Address** ______________________________ **City** ________________
State ________ **Zip** __________ **Phone#** ________________________

Whom may we thank for referring you?: ____

IT IS IMPORTANT THAT I KNOW ABOUT YOUR MEDICAL AND DENTAL HSTORY.THESE FACTS HAVE A DIRECT BEARING ON YOUR DENTAL HEALTH.THIS INFORMATION IS STRICTLY CONFIDENTIAL AND WILL NOT BE RELEASED TO ANYONE.THANK YOU FOR TAKING TIME TO COMPLETELY FILL OUT THIS QUESTIONAIRE.

MEDICAL HISTORY — Circle (Y) or (N) to any of the following that you have had or presently have

(Y/N) Do you currently have any health problems (Y/N) Are you under a Physicians Care now? **What For**? _______________________
What medications are you taking now? ____

(Y/N) Are you **PREGNANT?** **(Y/N) D**o you **SMOKE** or use **CHEWING TOBACCO**?

(Y/N) Heart Disease/Attack/Stroke	(Y/N) AIDS/HIVpos./ARC	(Y/N) Bruise easily	(Y/N) Angina Pectoris
(Y/N) Hepatitis A (infectious)	(Y/N) Emphysema	(Y/N) High Blood Pressure	(Y/N) Hepatitis B (serum)
(Y/N) Tuberculosis (TB)	(Y/N) Heart Murmur	(Y/N) Hepatitis C	(Y/N) Asthma
(Y/N) Rheumatic Fever	(Y/N) Liver Disease	(Y/N) Hay Fever/Sinus	(Y/N) Congenital Heart Lesions
(Y/N) Blood Transfusions	(Y/N) Allergies/Hives	(Y/N) Mitral Valve Prolapse	(Y/N) Drug Addiction
(Y/N) Diabetes	(Y/N) Artificial Heart Valve	(Y/N) Hemophilia (bleeding problems)	
(Y/N) Thyroid Disease	(Y/N) Heart Bypass Surgery	(Y/N) Epilepsy/Seizures	(Y/N) Arthritis
(Y/N)Anemia	(Y/N) Psychiatric Treatment	(Y/N) Cortisone Medicine	(Y/N) Kidney Trouble
(Y/N) Chemotherapy (Cancer/Leuk.)	(Y/N)Alcoholism	(Y/N) Heart Pacemaker	(Y/N) Fever Blisters
(Y/N) RadiationTreatment	(Y/N) Ulcers	(Y/N) Venereal Disease (Syphilis/Gonorrhea,etc.)	
(Y/N) Cosmetic Surgery	(Y/N) Taken PHENPHEN/REDUX?	(Y/N) Pain in Jaw Joints? YES /NO	

(Y/N) Artificial Joint (Hip,Knee) When? ________________________________
(Y/N)ARE YOU ALLERGIC TO ANY MEDICATIONS OR SUBSTANCES? IF SO, PLEASE List BELOW:
___________________ ____

(Y/N) ALLERGIC TO: Latex____Nitrous Oxide____Local Anesthesia **(Y/N) Are you currently taking birth control?**

DENTAL HISTORY — Please answer the following questions below.

How long since you last saw a dentist? ___________________________ Last complete Dental Exam date? ____________________________
Last Full Mouth Series X-rays Date? ___________________________ How do you feel about your teeth? ___________________________

Circle (Y) or (N) to the following questions:

(Y/N) Are you having problems now?
(Y/N) Are you unhappy with the appearance of your teeth?
(Y/N) Do you have discolored teeth that bother you?
(Y/N) Do your gums bleed easily?
(Y/N) Have you had any periodontal (gum) treatment?
(Y/N) Are you aware of grinding/clenching your teeth?
(Y/N) Have you worn Braces on your teeth (Orthodontics)?
(Y/N) Do you wear Dentures or Partials?
(Y/N) Are you apprehensive about dental treatment?
(Y/N) Would you like your smile to look different or better?
(Y/N) Do your gums feel tender or irritated?
(Y/N) Are your teeth sensitive to hot, cold, sweets, or pressure?
(Y/N) Do you get frequent headaches?

______________________	__________	______________________	__________
Patient Signature	**Date**	**Dentist Signature**	**Date**

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