HEALTH HISTORY Name _____Date_____

Medical History

Has there been any problem in your general health within the past 5 Years? (serious illness, hospitalization, surgery, etc.) If so, what was the problem?_____
_____

The date of your last medical check-up_____

Are you currently under the care of a physician? If so, for what? _____
_____

What drugs or medications do you take? (include aspirin, vitamins, etc.) _____
_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS? IF YOU ARE UNCERTAIN ABOUT THE QUESTION LEAVE IT UNANSWERED.

	YES	NO		YES	NO
Rheumatic fever (heart disease)	____	____	Diabetes	____	____
Heart trouble/heart attack/stroke	____	____	Prolonged healing	____	____
Heart murmur/mitral valve prolapse	____	____	Sores that do not heal	____	____
Pain in chest	____	____	Kidney troubles	____	____
Shortness of breath	____	____	Arthritis	____	____
Swollen ankles	____	____	Back problems	____	____
Blood disorders/Anemia	____	____	Radiation treatment	____	____
Abnormal bleeding	____	____	Chemotherapy	____	____
Bruise easily	____	____	Tuberculosis	____	____
Asthma	____	____	Lung Ailments	____	____
Low blood pressure	____	____	Ulcer/Colitis	____	____
Sinus problems	____	____	Joint Replacements	____	____
Hepatitis/Jaundice/Liver Disease	____	____	Allergies	____	____
HIV/AIDS	____	____	Allergic or unusual reaction		
Women: Are you pregnant	____	____	to any medications/drugs	____	____

Do you have any disease, condition, or problem not listed above that you think the doctor should know about? If so, what? _____

OFFICE USE:

Current medications	Dose and Frequency	Reason

Dental History

DO YOU HAVE OR HAVE YOU HAD OR DO YOU USE ANY OF THE FOLLOWING:

	YES	NO		YES	NO
Teeth sensitive to cold, heat, sweets, or pressure	____	____	Cigarettes, cigar, or pipe smoking	____	____
Bleeding Gums	____	____	Smokeless or chewing tobacco	____	____
Loose teeth	____	____	Manual toothbrush	____	____
Food impaction	____	____	Electric or Sonic toothbrush	____	____
Clenching or grinding of teeth	____	____	Water pik or oral irrigator	____	____
Burning of tongue	____	____	Dental Floss	____	____
Swelling or lumps in mouth	____	____	Toothpicks, Proxabrush, etc.	____	____
Frequent blisters on lips or mouth	____	____	Fluoride supplements(tablets,rinses,etc.)	____	____
Pain around ear	____	____	Instructions on correct brushing of teeth	____	____
Unusual sounds in ear while eating	____	____	Instructions on care of your gums	____	____
Bad breath	____	____	Periodontal (gum) treatment	____	____
Unpleasant taste	____	____	Root canal treatment	____	____
Mouth breathing	____	____	Orthodontic (braces) treatment	____	____
Oral habits (fingernail/cheek biting, thumb sucking, etc.)	____	____	Traumatic injuries to teeth or jaws	____	____
Unfavorable dental experience	____	____	Complications from extractions	____	____
			Complications with local anesthetics	____	____
			Regular dental exams and care	____	____

SMILE ASSESMENT	YES	NO
I am concerned about the appearance of my teeth or my smile	____	____
I am concerned about the whiteness/lack of whiteness of one or more of my teeth	____	____
I am concerned about the position or angle of one or more of my teeth	____	____
I am concerned about the shape of one or more of my teeth	____	____
In social situations, I am sometimes embarrassed by my teeth or smile	____	____
There are some things about my upper front teeth that I would like to change	____	____
There are some things about my lower front teeth that I would like to change	____	____
I have old fillings or previous dental treatment that is no longer satisfactory to me	____	____
I am missing one or more of my teeth	____	____
I am interested in learning more about esthetic dentistry	____	____

TO THE BEST OF MY KNOWLEDGE THE ABOVE IS CORRECT AND COMPLETE. I UNDERSTAND THAT I AM RESPONSIBLE FOR INFORMING THIS OFFICE OF ANY CHANGE IN THIS MEDICAL HISTORY.

Patient Signature _____Date _____

OFFICE USE:
Summary of Medical Status _____

_____

_____

Consultation with physician required YES ____ NO ____