HEALTH HISTORY

Patient's Name _____ Birthdate _____

Medications

List all medications you are currently taking. *** If you take natural supplements & herbs, list them here or ask for the "Natural Supplements" form.

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Do you take any bisphosphonates, such as Actonel, Boniva, Fosamax, or Zometa? Yes ☐ No ☐ I don't know ☐

Allergies

Are you allergic to any Medications? ☐ Yes ☐ No If yes, please check the items you are allergic to:

☐ Aspirin ☐ Barbiturates ☐ Codeine ☐ Iodine ☐ Penicillin ☐ Sulfa ☐ Latex

☐ Ibuprofen (Advil, Motrin) ☐ Acetaminophen (Tylenol)

☐ Local anesthetics (Novocain) ☐ Other: _____

Do you have any food allergies? ☐ Yes ☐ No If yes, please list: _____

Are you allergic to anything else? ☐ Yes ☐ No If yes, please list: _____

Dental History

****** PLEASE DO NOT DRAW LINES THRU BOXES: CHECK INDIVIDUALLY!!! ******

Reason(s) for today's visit: _____

Please mark each box below INDIVIDUALLY to indicate if you currently have **OR** ever had any of the following:

	Yes	No		Yes	No		Yes	No
Bad breath	☐	☐	Bleeding Gums	☐	☐	Blisters on lip or mouth	☐	☐
Click or pop in jaw	☐	☐	Dry mouth	☐	☐	Fingernail biting	☐	☐
Sores / Growths in mouth	☐	☐	Burning sensation on tongue	☐	☐	Chew on one side of mouth	☐	☐
Smoke / Chewing tobacco	☐	☐	Grind Teeth	☐	☐	Swollen / Tender gums	☐	☐
Jaw pain, tiredness	☐	☐	Lip or Cheek biting	☐	☐	Loose Teeth	☐	☐
Broken fillings	☐	☐	Mouth breathing	☐	☐	Pain when brushing	☐	☐
Orthodontic treatment	☐	☐	Periodontal treatment	☐	☐	Hot / Cold sensitivity	☐	☐
Sensitivity to sweets	☐	☐	Sensitivity when biting	☐	☐			

Habitual placement of objects between teeth or in mouth (ie. Pens, pins, nails, chewing tobacco, etc) Yes ☐ No ☐

How often do you brush? _____ How often do you floss? _____

Former dentist and location (OPTIONAL): _____

Medical History

*** PLEASE DO NOT DRAW LINES THRU BOXES: CHECK INDIVIDUALLY!!! ***

Physician's Name & Address: _____Date of last visit: _____

Please mark each box below INDIVIDUALLY to indicate if you currently have **OR** ever had any of the following:

	Yes	No		Yes	No		Yes	No
AIDS	☐	☐	Epilepsy	☐	☐	Rheumatic Fever	☐	☐
Anemia	☐	☐	Fainting or dizziness	☐	☐	Scarlet Fever	☐	☐
Arthritis, Rheumatism	☐	☐	Glaucoma	☐	☐	Shortness of breath	☐	☐
Artificial heart valves	☐	☐	Headaches / Migranes	☐	☐	Sinus trouble	☐	☐
Artificial joints	☐	☐	Cortisone Treatments	☐	☐	Skin rash	☐	☐
Asthma, COPD, or Lung Disease	☐	☐	Bell's Palsy	☐	☐	Special diet	☐	☐
Back problems	☐	☐	Hepatitis Type ____	☐	☐	Stroke	☐	☐
Bleed abnormally with extractons	☐	☐	Herpes	☐	☐	Swelling of ankles or feet	☐	☐
Blood Disorders / disease	☐	☐	High blood pressure	☐	☐	Swollen neck glands	☐	☐
Cancer	☐	☐	Low blood pressure	☐	☐	Thyroid Problems	☐	☐
Chemotherapy	☐	☐	Resting Pressure: _____ / _____			Tonsillitis	☐	☐
Chemical dependency	☐	☐	Jaw pain	☐	☐	Tumor or growth on head or		
Heart History:	☐	☐	Kidney disease	☐	☐	neck	☐	☐
Circulatory problems	☐	☐	Liver disease	☐	☐	Tuberculosis	☐	☐
Congenital Heart Lesion/Disease	☐	☐	Low blood pressure	☐	☐	Ulcer	☐	☐
Heart Disease / Problems	☐	☐	HIV	☐	☐	Unexplained weight loss	☐	☐
Endocarditis	☐	☐	Nervous problems	☐	☐	Venereal disease	☐	☐
Heart Attack	☐	☐	Organ Transplant	☐	☐	Osteoporosis	☐	☐
Murmurs / Mitral Valve Prolapse	☐	☐	Pacemaker	☐	☐	Women:		
Stents	☐	☐	Psychiatric care	☐	☐	Are you pregnant	☐	☐
Valve Replacement / Issues	☐	☐	Radiation treatment	☐	☐	Are you nursing	☐	☐
Diabetes	☐	☐	Respiratory Disease	☐	☐	Do you use oral contraceptives	☐	☐

Do you take prophylactic antibiotics for dental work? ☐ Yes ☐ No If yes, why? _____

In Case Of An Emergency

Who should we contact?

Name: _____

Relationship: _____

Cell Phone: _____

Home Phone: _____

Work Phone: _____

Certification

I hereby certify that all of the information provided on this form is as complete and accurate as possible.

_____ _____
Signature Date

Updates

_____ _____
Signature Date

_____ _____
Signature Date

Version #4 10/7/22

Doctor's Notes

_____

_____

_____

_____

_____

_____

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_____

_____

Doctor Review

Signature	Date	Signature	Date
_____		_____	
_____		_____	