# HEALTH HISTORY

YOUR MEDICAL INFORMATION WILL HELP US PLAN FOR YOUR CARE AND HELP TO SERVE YOU BETTER.

## PERSONAL INFORMATION

Full Legal Name: _____ Date Of Birth: _____
Nickname: _____ Pronouns: _____

## PHYSICIAN INFORMATION

Physician Information: _____ Date Of Last Visit: _____
Address: _____
City, State, Zip: _____ Phone Number: _____

## KNOWN ALLERGIES

☐ None ☐ Penicillin ☐ Latex
☐ Local Anesthetic ☐ Codeine ☐ Other: _____

## DO YOU OR HAVE YOU EVER BEEN DIAGNOSED WITH OR TREATED WITH:

☐ No ☐ Yes Anemia
☐ No ☐ Yes Arthritis
☐ No ☐ Yes Artificial Joint: Type: _____ Date: _____
☐ No ☐ Yes Artificial Heart Valve
☐ No ☐ Yes Asthma
☐ No ☐ Yes Cancer: Type: _____
☐ No ☐ Yes Chemical Dependency
☐ No ☐ Yes Chemotherapy
☐ No ☐ Yes Congenital Heart Disease
☐ No ☐ Yes Diabetes: Type: _____
☐ No ☐ Yes Epilepsy
☐ No ☐ Yes Excessive Or Prolonged Bleeding
☐ No ☐ Yes Fainting Spells
☐ No ☐ Yes Lung Disease (e.g. COPD)
☐ No ☐ Yes Glaucoma
☐ No ☐ Yes Heart Murmur
☐ No ☐ Yes Heart Pacemaker
☐ No ☐ Yes Heart Surgery
☐ No ☐ Yes Heart Trouble
☐ No ☐ Yes Hepatitis: Type: _____
☐ No ☐ Yes High Or Low Blood Pressure (circle)
☐ No ☐ Yes HIV / AIDS
☐ No ☐ Yes Jaundice
☐ No ☐ Yes Oral Or IV Bisphosphonates
☐ No ☐ Yes Organ Transplant
☐ No ☐ Yes Osteoporosis
☐ No ☐ Yes Psychiatric Care
☐ No ☐ Yes Radiation: Type: _____ Date: _____
☐ No ☐ Yes Rheumatic Fever
☐ No ☐ Yes Sexually Transmitted Infection
☐ No ☐ Yes Sinus Trouble
☐ No ☐ Yes Stroke
☐ No ☐ Yes Thyroid Problem
☐ No ☐ Yes Tuberculosis
☐ No ☐ Yes Ulcers

## ARE YOU CURRENTLY

☐ No ☐ Yes Using tobacco / nicotine Type and amount: _____
☐ No ☐ Yes Pregnant / nursing Due date: _____
☐ No ☐ Yes Taking any medications (prescription or over the counter): _____

## HAVE YOU HAD

☐ No ☐ Yes History of using tobacco / nicotine Type and amount: _____
Any other serious illness, hospitalization or accident: _____

Anything else you would like us to know: _____

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# DENTAL HISTORY

## PREVIOUS DENTAL OFFICE INFORMATION

Office/Dentist Name: _____

Address: _____

City, State, Zip: _____ Phone: _____

Date Of Last Visit: _____ Date Of Last Radiographs: _____

Dental Treatment Recommended But Not Completed: _____

Reason For Changing Offices: _____

How Often Do You Brush Your Teeth: _____ How Often Do You Floss Your Teeth: _____

**DO YOU HAVE**

☐ No ☐ Yes Bad breath (Halitosis)
☐ No ☐ Yes Bleeding gums when brushing or flossing (Gingivitis)
☐ No ☐ Yes Clenching or grinding of your teeth (Bruxism)
☐ No ☐ Yes Crowded or crooked teeth
☐ No ☐ Yes Food collecting between your teeth
☐ No ☐ Yes History of periodontal disease: Date of initial periodontal treatment: _____
☐ No ☐ Yes Jaw pain (TMD)
☐ No ☐ Yes Loose teeth
☐ No ☐ Yes Receding gums
☐ No ☐ Yes Sensitivity to chewing or pressure
☐ No ☐ Yes Sensitivity to cold/hot
☐ No ☐ Yes Sensitivity to sweets
☐ No ☐ Yes Snoring
☐ No ☐ Yes Swelling
☐ No ☐ Yes Tooth pain

☐ No ☐ Yes Are you happy with the appearance of your smile? If not, why? _____

☐ No ☐ Yes Are you interested in preventing dental problems by having regular dental care?

Is there anything else you would like to share so we can make your dental visit more comfortable and convenient? _____

PATIENT OR GUARDIAN SIGNATURE: _____ DATE: _____

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