PATIENT'S HEALTH HISTORY

1) **How did you hear about us? (circle one)**
   -Advertisement
   -Insurance Company
   -Drove by
   -Referred by: _____

2) **Why have you come to see us today?**

3) **Is there anything you would change about your smile?**

4) **Are you interested in any cosmetic changes, such as Botox or Fillers?**

5) **How long has it been since your last dental visit?** (circle one)

   - 6 months or less
   - 6-12 months
   - 1-2 years
   - 2+ years

6) **Do your gums bleed when you brush?**

7) **Have you ever had a deep cleaning?**

8) **What type of toothbrush are you currently using?** Manual or electronic? If electronic, then what kind? (Sonicare, Oral-B?)

9) **Current medications list** (perfect spelling is not required)

10) **Are you currently under a physician's care for any specific condition or illness?**

11) **Last visit to a physician? _____**

12) **Physician's name and phone number:_____**

13) **Have you ever been hospitalized or had a major operation?**

14) Have you been to the emergency room within the last year?

15) Have you ever been involved in a serious head or neck injury?

16) Do you take, or have you ever taken, Phen-Fen or Redux?

17) Are you on a special diet?

18) Do you use tobacco?

19) Do you drink alcohol?

20) **Do you use controlled substances?** (This information is for medical purposes only. For example, your use of recreational drugs may affect how dental anesthesia reacts in your body. Please be honest.) Circle one: Yes / No

-if yes, how often and what kind?_____

21) Do you take, or have you ever taken, Fosamax, Actonel, Boniva, Aredia or Zometa?

22) Do you require a pre-med? (For Heart condition, prosthetics, etc.)

23) For our female patients: are you pregnant, trying to get pregnant or nursing?

24) Are you allergic to any of the following: (Mark all that apply)

-Acrylic
-Aspirin
-Codeine
-Food Allergies
-Latex
-Local anesthetics
-Metal
-Penicillin/Amoxicillin
-Sulfa Drugs
-Tetracycline
-Other:_____

25) Do you have, or have you ever had any of the following? (Mark all that apply)

- AIDS / HIV Positive
- Alzheimer's Disease
- Anemia - Chronic
- Angina Pectoris
- Antipsychotic Medications
- Arthritis
- Artificial Heart Valve
- Artificial Joint
- Asthma
- Autism
- Cancer
- Chemical Dependency - Alcohol / Drugs
- Coagulation Disorder
- Congenital Heart Disorder / Defect
- Congestive Heart Failure
- Coumadin Therapy
- Crohn's Disease
- Depression
- Diabetes
- Epilepsy or Seizures
- Excessive Bleeding
- Gastrointestinal Condition
- Glaucoma
- Heart Attack
- Heart Murmur (for pre-med)
- Heart Valve Replacement
- Hepatitis B or C
- Herpes / Cold Sores
- High Blood Pressure
- Kidney Disease
- Leukemia
- Liver Disease

- Meniere's Disease (dizziness)
- Mental Illness
- Mitral Valve Prolapse
- Organ Transplant
- Pacemaker
- Psychiatric Care
- Radiation / Chemotherapy
- Respiratory Condition
- Rheumatic Fever
- Rheumatism
- Shingles
- Spina Bifida
- Stroke
- Thyroid Condition
- Tuberculosis
- Tumors
- Ulcers
- Any other condition or illness not listed: :

Patient's name: _____

Patient's Signature _____

Parent's Signature (if patient is a minor) :_____

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS INFORMATION TO YOUR BEST ABILITY ☺