HEALTH HISTORY

Immediate Dental Concern_______________________________Date of last exam_________

Previous Dentist and Address_____________________________Phone ( ) ___________

Physician's name and address _____________________________Phone ( ) ___________

Dental History

Do you have any of the following? Please indicate with an(X).

___ History of TMJ
___ Popping or locking of jaw
___ Clenching/grinding of teeth
___ Nightguard
___Teeth sensitive to
hot ___cold ___sweets ___pressure___
___Dry mouth

___History of periodontal disease
___Sleep apnea/snoring
___GERD(acid reflux)
___ Bad breath
___ History of canker sores or fever blisters
___Gagger
___Dentures

Level of anxiety about treatment	**Low**	**Medium**	**High**
Level of current dental heath	**Low**	**Medium**	**High**

Medical History

Do you or have you had any of the following? Indicate with an (X).

___ No known allergies
___ Allergies to anesthetics
___ Allergy to Latex
___ Allergy to foods
___ Allergy to metals
___ Allergy to medications
List:___________
____
___ Heart condition
___ Mitral valve prolapse
___ Pace maker
___ Functional murmur
___ Heart attack :when_______
___Artificial heart valve
___ Joint replacement
where___________
when___________

___ High blood pressure
___ Stroke : when______
___ AIDS, HIV /STD
___ Drug / Alcohol addiction
what drug_____________
when treated __________
___ Current use alcohol,other drugs
What____________
___Neurological disorder
___ Depression
___ Anxiety
___ Arthritis
___ Diabetes
___ Developmentally disabled
___ Epilepsy
___Intestinal disease
___Psychological/Psychiatric treament

___ Kidney disease
___ Liver disease
___ Hepatitis: A, B, or C when?_____
___ Blood disorders
___ Abnormal bleeding
___Cancer
what kind_______
when _________
___ Lung disease
___ Asthma
___ Emphysema
___ Tuberculosis
___ Tobacco use
how much? __________
__Currently Pregnant ?
Due date: _________

Describe any other medical condition:____

List Medications/Supplements You Are Taking: ____

____

Authorization and Release:
To the best of my knowledge, the above information is correct. I shall inform the dentist if I have changes in my health status or medications at each appointment. I grant the right to the dentist to release dental or medical information as needed to third party payees or other health professionals.

Date:_______________ Signature:____
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(parent or guardian, if minor)