

Health and Dental History

Name _____ Date _____

Have you been under the care of a medical doctor during the past 5 years? Yes No

If yes, list reason(s) _____

Name of M.D. _____ Phone _____

List current medications you take including aspirin and nutritional supplements _____

Have you had an adverse reaction to any medications in the past? Yes No

If Yes, list and describe _____

Allergies Yes No

List _____

Heart Disease/Surgery Yes No

Describe _____

High Blood Pressure Yes No

Stroke Yes No

Asthma/Breathing Problem Yes No

Emphysema/Lung Disease Yes No

Hepatitis/Liver Disease Yes No

Joint Replacement Yes No

If yes, when? _____

Kidney Disease Yes No

Cancer Yes No

If yes, describe _____

Epilepsy/Seizures Yes No

Diabetes Yes No

H.I.V. Yes No

Neurological Disorder Yes No

Psychiatric/Psychological issue Yes No

Fainting/Dizziness Yes No

Bleeding Problem Yes No

Glaucoma/Eye Problem Yes No

Have you taken Bisphosphonates, such as Fosamax,

Boniva or other? Yes No

Do you use tobacco? Yes No

How many alcohol drinks per week? _____

Do you use recreational drugs? Yes No

Insomnia/Frequent Waking Yes No

Ear Congestion Yes No

Ringling Ears/Tinitis Yes No

Headaches/Migraines Yes No

Difficulty Swallowing Yes No

Snoring/Sleep Apnea Yes No

Neck pain Yes No

Posture Problems Yes No

Do you see a chiropractor Yes No

Tingling Arms/Fingers Yes No

Facial Pain Yes No

Jaw Pain Yes No

Jaw Popping/Jaw Joint Noise Yes No

Limited Jaw Opening Yes No

Loose Teeth Yes No

Jaw Clenching/Teeth Grinding Yes No

Sensitive Teeth Yes No

Difficulty Chewing Yes No

Bite Problem Yes No

Trigeminal Neuralgia Yes No

Have you had orthodontics? Yes No

Crowded tongue Yes No

Does food pack between teeth? Yes No

Do your gums bleed? Yes No

Does your breath concern you? Yes No

Other problems not listed here? Yes No

If yes, describe _____

Women Only:

Are you pregnant? Yes No

Are you planning a pregnancy? Yes No

Are you nursing? Yes No

Are you taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency who may release such information to you. I will notify the doctor of change in my health and medication.

Patient (Print Name)

(Patient Signature)

(Date)