Patient Name:_____

PATIENT HEALTH HISTORY

These questions assure that treatment will take in to consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care. **Please circle Yes or No for each question**.
Please comment on how we may make your visit as comfortable as possible. Thank You.

MEDICAL HISTORY

1. Are you in good health?……..……..…Yes No
2. Date of last physical examination _____
3. Do you have a Physician? Name _____City _____Phone Number (____)_____Yes No
4. Are you currently under the care of a physician? If yes for what condition? _____Yes No
5. Have you ever had any serious illness or operation or hospitalization?……...Yes No
   If yes, please explain:_____
6. Are you taking any medication? If yes, please list:_____Yes No
7. Have you ever been pre-medicated with antibiotics for any dental treatment? ……..…..Yes No
8. Are you allergic to: □Penicillin □Tetracycline □Sulfa Drugs □Aspirin □Codeine □Latex □Metal □Other _____Yes No
9. Have you ever taken Bisphosphonates(Fosamax) for Osteoporosis? ……Yes No
10. Do you have or have you had any of the following? **Please √ yes or no for every item.**

Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
□ □Bells Palsy	□ □Cold Sores	□ □Sinus Trouble	□ □Blood Transfusion	□ □Mental Disorder	□ □High Blood Pressure
□ □Tonsillitis	□ □Herpes	□ □Thyroid Disease	□ □Excessive Bleeding	□ □Nervous Disorder	□ □**Mitral Valve Prolapse**
□ □Stroke	□ □Stomach Ulcers	□ □Low Blood Sugar	□ □Sickle Cell Disease	□ □Psychiatric Treatment	□ □**Heart Valve replacement**
□ □HIV/AIDS	□ □Bruise Easily	□ □Cerebral Palsy	□ □Artificial Prosthesis	□ □Kidney Disease	□ □Angina Pectoris
□ □Diabetes	□ □Rheumatic Fever	□ □Fainting/Seizure	□ □Joint Replacement	□ □Asthma	□ □Heart Attack/Ailment
□ □Glaucoma	□ □Liver Disease	□ □Epilepsy	□ □Difficulty swallowing	□ □Tuberculosis	□ □Heart Pacemaker
□ □Arthritis	□ □Hepatitis	□ □Phys. Handicapped	□ □Hearing Impaired	□ □Emphysema	□ □Heart Murmur
□ □Anemia	□ □Blood Disease	□ □TMJ Pain	□ □Cancer/Chemotherapy	□ □Radiation Treatment	□ □Heart Surgery
	□ □Chronic back Pain	□ □Chronic Headaches	□ □Other_____		

11. Do you have any disease, condition, or problem not listed that I should know about? ……..…… Yes No
12. Do you smoke or use any tobacco products? How much per day?_____…….. Yes No
13. (Women) Is there a possibility you may be pregnant?……... Yes No
14. (Women) Do you have any problem associated with your menstrual period? …….. Yes No
15. (Women) Do you take birth control pills?…….. Yes No

DENTAL HISTORY

1. Previous Dentist _____ City _____Phone_____
2. Do you have any specific problem? Explain _____ Yes No
3. Do you have or have you had any of the following? Please √……Yes No
   □Bad Breath □Loose Teeth □Headaches □Bleeding Gums □Sensitive Teeth □Jaws Pop or Lock
   □Sinus Trouble □Injury □Oral Surgery □Orthodontics □Periodontics
   Explain: _____
4. Are you a participant in any sport? Which Sport? _____ Yes No
5. Does dental treatment make you nervous? □Slightly □Moderately □Severely…… Yes No
6. Have you ever had any unfavorable reaction from local anesthetics?…… Yes No
7. Have you had any serious trouble with any previous dental treatment? …… Yes No
8. How long since your last dental x-rays? _____dental treatment? _____
9. Would you prefer to be pre-sedated? □Nitrous oxide □Oral medication…….. Yes No

All of the preceding are true to the best of my knowledge. I will inform the doctor of any future changes.

PATIENT, PARENT/GUARDIAN SIGNATURE: _____Date: _____

DENTIST SIGNATURE: _____Date: _____