Last Name: _____ First Name: _____ DOB: _____

Health History Form

Dental and Medical Health History:

Please indicate if you currently have or have had any of the following. Checking the box indicates **"Yes"**, leaving blank indicates **"No"**.

Dental Conditions

- ☐ Bad Breath
- ☐ Blisters on Lips or Mouth
- ☐ Burning Sensation on Tongue
- ☐ Chew on One Side of Mouth
- ☐ Clench or Grind Teeth
- ☐ Dry Mouth
- ☐ Food Collection Between Teeth
- ☐ Growths or Sore Spots in Your Mouth
- ☐ Gums Swollen, Tender or Bleeding
- ☐ Head/Neck/Jaw Pain or Aches
- ☐ Lip or Cheek Biting
- ☐ Loose Teeth or Broken Fillings
- ☐ Mouth Breathing
- ☐ Orthodontic Treatment
- ☐ Nitrous Oxide
- ☐ Periodontal Treatment
- ☐ Sensitivity to Pressure/Cold/Heat/Sweets
- ☐ Smokeless Tobacco
- ☐ Cigarette, Pipe, or Cigar Smoking

If yes, Frequency: _____ Quantity: _____

Allergies

- ☐ Aspirin
- ☐ Latex
- ☐ Penicillin
- ☐ Other Allergies (List Below)

Medical Conditions

- ☐ Abnormal Bleeding
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma:
  Required Hospitalization ☐
  Have you used steroids? ☐
  Date of Last Episode
  _____
- ☐ Blood Transfusion
- ☐ Blood Disease, Clotting Disorder
- ☐ Blood Thinners
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Contact Lenses
- ☐ Cortisone Treatments
- ☐ Cough, Persistent or Bloody
- ☐ Diabetes: A1C _____
  Date Taken _____
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis: Type _____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Any Immune Deficiency
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Pacemaker
- ☐ Pregnant/Nursing:
  Due Date _____
- ☐ Radiation Treatments
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sinusitis
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Sickle Cell Anemia
- ☐ Skin Rash
- ☐ Slow Healing Wounds
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or Growth on Head and/or Neck
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Weight Loss, Unexplained
- ☐ Other Conditions (Explain Below)

Other Allergies: List all additional allergies you have below.

Other Conditions: List all additional conditions or information below.

Medications: List any medications you are taking below.

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Premedication ☐ **Yes** ☐ **No**
Do you have to take pre-medication prior to receiving dental treatment? If Yes, please explain:

Anesthetic Allergy ☐ **Yes** ☐ **No**
Have you ever had an allergic reaction to Novocaine, local or general anesthetics? If Yes, please explain:

Joint Replacement ☐ **Yes** ☐ **No**
Have you had an orthopedic total joint (hip knee, replacement? If Yes, have you had any complications?

Bisphosphonates ☐ **Yes** ☐ **No**
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Boniva, Reclast, Prolia, Didronel, Zometa) for osteoporosis or Paget's Disease?

Do you use controlled substances (drugs)? ☐ Yes ☐ No
If Yes, please specify what how often below:

Do you drink alcoholic beverages? ☐ Yes ☐ No
If Yes, how much alcohol did you drink in the last 24 hours? _____
If Yes, how much do you typically drink in a week? _____

Have you ever had trouble from previous dental care? ☐ Yes ☐ No
If Yes, please explain:

Authorization and Release: I have read and answered the above questions to the best of my knowledge.

_____ _____

Patient or Guardian Signature Date Doctor Signature Date