Health History

Your name_____Today's date_____

Physician name and phone _____Date of last visit_____

Are you in good health?	☐ Yes ☐ No
Have you ever been instructed on the proper care of your teeth?	☐ Yes ☐ No
Are you willing to make an effort to keep your teeth?	☐ Yes ☐ No
Have you been hospitalized in the last 5 years?	☐ Yes ☐ No
Have you ever responded adversely to any medical/dental treatment or anesthetic?	☐ Yes ☐ No
Have you ever premedicated with antibiotics before a dental appointment?	☐ Yes ☐ No

For Women: Are you Pregnant? ☐ Yes ☐ No Are you Nursing? ☐ Yes ☐ No
Taking any hormones or birth control pills? ☐ Yes ☐ No

List all medications or supplements_____for_____
that you are taking: _____for_____
_____for_____

Are you taking aspirin daily? ☐ Yes ☐ No How many mg? _____

List all medications that you are allergic to: _____

Circle any of the following that you have had or are currently being treated for:

Alcohol Use	Excessive Thirst	Osteoporosis
Allergies	Fainting or Dizziness	Pacemaker
Anemia	Glaucoma	Psychiatric Care
Arthritis	Heart Murmur	Radiation Therapy
Artificial Heart Valve	Heart Problems	Rheumatic Fever
Artificial Joints	Heart Surgery	Shortness of Breath
Asthma	Hepatitis Type_____	Sinus Problems
Back Problems	High Blood Pressure	Steroid Treatment
Bleeding Problems	HIV/AIDS	Stomach Problems
Cancer	Kidney Problems	Stroke
Chemical Dependency	Liver Problems	Swelling of Ankles
Chemotherapy	Low Blood Pressure	Tobacco Use
Diabetes	Lung Problems	Thyroid Problems
Diet Pills	Mitral Valve Prolapse	Ulcer
Epilepsy or Seizures	Nervous Problems	Weight Loss

Other _____

Circle any of the following that you have had or having problems with:

Bleeding Gums	Grinding/Clenching Teeth	Sensitivity when biting
Deep Scalings	Gum Surgery	Sores/Lumps in Mouth
Dental Pain	Sensitivity to Hot/Cold	Tender Jaw Joint

Other_____

Is there anything else we should know about your medical or dental history? _____

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