Healthy Life Dental – *Healthy teeth, happy life*

HEALTH HISTORY

DATE ____-____-____ PATIENT NAME ______________________________

AGE ______________ SEX M / F HEIGHT ________ WEIGHT LBS. _______

In case of an emergency, contact (person) ______________________________

Phone # ( ) _______-____________

INSTRUCTIONS:
Answer all questions and fill in the blank spaces when indicated. Answers to the following questions are for our records only and will be kept confidential.

Why are you **here** today? ______________________________

When was your **last** visit to a **dental** office? ______/______/______

When were your last dental **x-rays** taken? ______/______/______

Are those x-rays **available**? ❑ Yes ❑ No

PRIOR DENTIST'S NAME and PHONE NUMBER: ______________________________ (______)____________

1. Are you in poor health? ❑ Yes ❑ No
2. Have you had any serious illness, an operation, or hospitalization in the last 5 years? ❑ Yes ❑ No
   If so, what was the problem? ______________________________
3. Are you pregnant? ❑ Yes ❑ No
4. Do you have allergies, hives or a skin rash? ❑ Yes ❑ No
5. Are you allergic to latex or rubber products? ❑ Yes ❑ No
6. Do you have any blood disorder such as anemia? ❑ Yes ❑ No
7. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your mouth, head or neck? ❑ Yes ❑ No
8. Are you employed in any situation that exposes you regularly to x-rays or other ionizing radiation? ❑ Yes ❑ No
9. Do you have or are you being treated for tuberculosis? ❑ Yes ❑ No
10. Do any of your teeth hurt? Which ones? ❑ Yes ❑ No
11. Do you wear a partial denture or any other removable dental appliance? ❑ Yes ❑ No

1. Has there been any change in your general health within the past year? ❑ Yes ❑ No
2. Are you currently under the care of a physician ❑ Yes ❑ No
   A. If so, what is the condition being treated ______________________________
3. The name and address of my physician is
   ____
   ____
   ____
4. Do you have or have you had any of the following diseases or problems:
   A. Damaged heart valves or artificial heart valves ❑ Yes ❑ No
   B. Congenital heart lesions or murmurs ❑ Yes ❑ No
   C. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke, or other) ❑ Yes ❑ No
      1) Do you have pain in your chest upon exertion? ❑ Yes ❑ No
      2) Are you ever short of breath after mild exercise? ❑ Yes ❑ No
      3) Do your ankles swell? ❑ Yes ❑ No
      4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep? ❑ Yes ❑ No
      5) Do you have a cardiac pacemaker? ❑ Yes ❑ No
   D. Low blood pressure ❑ Yes ❑ No
   E. Sinus trouble ❑ Yes ❑ No
   F. Asthma ❑ Yes ❑ No
   G. Emphysema or respiratory problems ❑ Yes ❑ No
   H. Persistent cough or cough up blood ❑ Yes ❑ No
   I. Fainting spells or seizures ❑ Yes ❑ No
   J. Diabetes ❑ Yes ❑ No
      1) Do you urinate (pass water) more than 6 times a day? ❑ Yes ❑ No
      2) Are you thirsty much of the time? ❑ Yes ❑ No
      3) Does your mouth frequently become dry? ❑ Yes ❑ No
   K. Kidney trouble ❑ Yes ❑ No
   L. Stomach troubles/ulcers ❑ Yes ❑ No
   M. Hepatitis, jaundice or liver disease ❑ Yes ❑ No
   N. Sexually transmitted disease ❑ Yes ❑ No
   O. HIV/AIDS ❑ Yes ❑ No
   P. Herpes ❑ Yes ❑ No
   Q. Arthritis or painful, swollen joints ❑ Yes ❑ No
   R. Do you have a prosthetic hip ❑ joint prosthesis ❑ implants ❑ bone plates ❑ or screws ❑
      other ______________________________
5. Have you had abnormal bleeding associated with previous surgery, trauma or dental extractions? ❑ Yes ❑ No
   A. Do you bruise easily? ❑ Yes ❑ No
   B. Have you ever required a blood transfusion? ❑ Yes ❑ No
      If so, explain the circumstances ______________________________
6. Do you use or have you used any of the following:
   1. Tobacco: smoke _____ smokeless (chewing) _____ ❑ Yes ❑ No
      Quantity per day _____
   2. Alcohol _____ Quantity per day _____ ❑ Yes ❑ No
   3. Recreational drugs ❑ Yes ❑ No
7. Have you taken the diet medication Redux® (Fen-Phen)? ❑ Yes ❑ No
8. Are you taking any medications ❑ Yes ❑ No
   If yes, indicate which.
   Antibiotics or sulfa drugs ❑ Anticoagulants (blood thinners) ❑
   Medicine for high blood pressure ❑ Cortisone (steroids) ❑
   Antidepressants ❑ Sedatives ❑ Antihistamines ❑ Aspirin ❑
   Insulin, tolbutamide (orinase) or similar drug ❑
   Digitalis or drugs for heart trouble ❑ Nitroglycerin ❑
   Oral contraceptives or other hormonal therapy ❑
   Medications to treat osteoporosis such as Fosamax, Aredia, Boniva, Zometa (Bisphosphonates) ❑ Herbal remedies ❑
   Any other drug or medicine ______________________________
9. Are you allergic or have you reacted adversely to any of the following:
   Local anesthetics ❑ Yes ❑ No
   Penicillin or other antibiotics ❑ Yes ❑ No
   Sulfa drugs ❑ Yes ❑ No
   Barbiturates, sedatives or sleeping pills ❑ Yes ❑ No
   Aspirin ❑ Yes ❑ No
   Iodine ❑ Yes ❑ No
   Codeine or other narcotics ❑ Yes ❑ No
   Nickel or other metals ❑ Yes ❑ No
   Other allergies ❑ Yes ❑ No
10. Are you wearing contact lenses? ❑ Yes ❑ No
11. Do you have any problems associated with your menstrual period? ❑ Yes ❑ No
12. Are you nursing? ❑ Yes ❑ No
13. Do you have any disease, condition, or problem not listed above that you think I should know about? ❑ Yes ❑ No

Healthy Life Dental

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DENTAL HISTORY :

14. Is there anything about your teeth or smile that you would like to change? ❑ Yes ❑ No
    If so, explain ______
15. Have you had any serious trouble associated with any previous dental treatment? If so, explain ______ ❑ Yes ❑ No
16. How often do you brush your teeth? ______ When? ______
17. How often do you floss? ______ When? ______
18. Do your gums bleed or hurt? ❑ Yes ❑ No
19. Are any of your teeth sensitive to:
    Hot ❑ Cold ❑ Sweets ❑ Pressure ❑ ❑ Yes ❑ No
20. Does food get caught in your teeth? ❑ Yes ❑ No
21. Do you have frequent headaches ❑ neck aches ❑ or shoulder aches? ❑ ❑ Yes ❑ No
22. Do you clench or grind your teeth? ❑ Yes ❑ No
23. Have you experienced any pain or soreness in the muscles of your face or around your ear? ❑ Yes ❑ No
24. Does your jaw click or pop? ❑ Yes ❑ No
25. Do you wear any type of denture or partial denture? ❑ Yes ❑ No
    A. Date of placement ____ / ____ / ____
    B. Is there anything about the denture that you would like to change? ❑ Yes ❑ No

FOLLOW UP to Medical History by DENTIST ONLY ______

I hereby certify that I have read the foregoing and have filled out this health questionnaire completely. I have advised you of all medical problems of which I am aware. I further certify that I, the undersigned, consent to the performing of x-rays and examination.

SIGNATURE OF **PATIENT** or **Guardian** if patient is a minor ______ DATE ______-______-______

SIGNATURE OF **DENTIST** ______ DATE ______-______-______

UPDATE	Date	Comments	Doctor Signature	Patient Signature
UPDATE				
UPDATE				
UPDATE				
UPDATE				
UPDATE				
UPDATE				
UPDATE				