



## PATIENT INFORMATION AND HEALTH HISTORY FORM

### DENTAL HISTORY

Reason for today's visit \_\_\_\_\_ Date of last dental visit \_\_\_\_\_

Former Dentist \_\_\_\_\_ Date of last dental x-rays \_\_\_\_\_

Address \_\_\_\_\_

Have you had any of the following:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad breath                    | <input type="checkbox"/> Grinding your teeth            | <input type="checkbox"/> Sensitivity to heat            |
| <input type="checkbox"/> Bleeding gums                 | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets          |
| <input type="checkbox"/> Clicking or popping jaw       | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity when biting        |
| <input type="checkbox"/> Cold Sores/Fever Blisters     | <input type="checkbox"/> Radiation treatment            | <input type="checkbox"/> Sores or growths in your mouth |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold            | <input type="checkbox"/> Surgery to mouth or gums       |

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

Describe any dental problem \_\_\_\_\_

Have you ever had a problem with a dental appointment? \_\_\_\_\_

How would you describe your current dental health?  Good  Fair  Poor

What, if anything, would you change about your smile? \_\_\_\_\_

### MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you had any serious illnesses, surgeries or hospitalization?  Yes  No If yes, describe \_\_\_\_\_

Are you under a doctor's care now?  Yes  No If yes, for what? \_\_\_\_\_

Have you had a change in your health in the past year  Yes  No If yes, describe \_\_\_\_\_

Have you ever been told you need to be premedicated or take antibiotics before dental work?  Yes  No If yes, for what? \_\_\_\_\_

How would you rate your current general health?  Good  Fair  Poor

Have you taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).  Yes  No

(Women) Are you pregnant?  Yes  No Nursing?  Yes  No Taking birth control pills?  Yes  No

Have you had any of the following:

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Chest Pains          | <input type="checkbox"/> Hemophilia/other bleeding disorder | <input type="checkbox"/> Respiratory Disease        |
| <input type="checkbox"/> Arteriosclerosis       | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hepatitis/Jaundice                 | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Arthritis, Rheumatism  | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> High Blood Pressure                | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Cough, Persistent    | <input type="checkbox"/> High Cholesterol                   | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Artificial Joints      | <input type="checkbox"/> Cough up Blood       | <input type="checkbox"/> HIV/AIDS                           | <input type="checkbox"/> Sickle Cell Disease/trait  |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Jaw Pain                           | <input type="checkbox"/> Sinus Trouble/Hay fever    |
| <input type="checkbox"/> Back Problems          | <input type="checkbox"/> Epilepsy/Seizures    | <input type="checkbox"/> Kidney Disease                     | <input type="checkbox"/> Skin Rash/Hives            |
| <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Liver Disease                      | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Bruise Easily          | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Mitral Valve Prolapse              | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Bypass                 | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Nervous Disorders                  | <input type="checkbox"/> Tobacco Use past/present   |
| <input type="checkbox"/> Cancer/Tumors          | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Pacemaker                          | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Chemical Dependency    | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Radiation Treatment                | <input type="checkbox"/> Ulcer                      |
| <input type="checkbox"/> Chemotherapy           |   |   | <input type="checkbox"/> Venereal Disease           |



**PATIENT INFORMATION AND HEALTH HISTORY FORM**

**Medications**

List any medication (Doctor prescribed or over the counter) you are currently taking and the correlating diagnosis:

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Are you allergic to:

Penicillin

Codeine

Aspirin

Local Anesthetics

Other Allergies: \_\_\_\_\_

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Is there anything that you feel is important but was not covered in this questionnaire: \_\_\_\_\_

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The information presented on this form is correct to the best of my knowledge. I understand that the information contained herein will be held in strict confidence.

\_\_\_\_\_  
Signature of patient or parent if minor

Date \_\_\_\_\_

**Updates (For Future Appointments)**

\_\_\_\_\_  
Date Health Change Signature

\_\_\_\_\_  
Date Health Change Signature

\_\_\_\_\_  
Date Health Change Signature