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:

[ ] Bad breath	[ ] Grinding your teeth	[ ] Sensitivity to heat
[ ] Bleeding gums	[ ] Loose teeth or broken fillings	[ ] Sensitivity to sweets
[ ] Clicking or popping jaw	[ ] Periodontal treatment	[ ] Sensitivity when biting
[ ] Cold Sores/Fever Blisters	[ ] Radiation treatment	[ ] Sores or growths in your mouth
[ ] Food collection between teeth	[ ] Sensitivity to cold	[ ] 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:

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

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Medications

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

_____
_____
_____
_____

Are you allergic to:

[ ] Penicillin [ ] Codeine
[ ] Aspirin [ ] Local Anesthetics

Other Allergies: _____
_____
_____

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

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.

_____ Date _____
Signature of patient or parent if minor

Updates (For Future Appointments)

Date	Health Change	Signature
Date	Health Change	Signature
Date	Health Change	Signature