

MATTHEW RYAN, D. D. S.

HEALTH HISTORY

PATIENT NAME: _____

DATE OF BIRTH: _____

Please answer each of the following questions. Your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and that there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This information will not be used to discriminate.

DENTAL INFORMATION

Have you had any recent dental/oral discomfort or pain? **YES NO**

Do your gums bleed when you brush your teeth? **YES NO**

Are your teeth sensitive to cold, hot, biting pressure, or sweets? **YES NO** Please specify: _____

Do you have jaw soreness, headaches, earaches, or neck pain? **YES NO** Please specify: _____

When was your last dental examination? _____

Have you had difficulty associated with any previous dental treatment? If so, please explain. _____

(optional)

How do you feel about the appearance of your teeth? _____

Please add any comments or questions about dental care, dental products or materials, your oral health care, or this dental practice that you would like addressed specifically. _____

MEDICAL INFORMATION

Do you have a primary physician? **YES NO** If so, please provide his/her name and contact information.

When was your last physical examination? _____

Has there been any change in your general health or adverse medical event in the last five years? **YES NO**

If so, please explain. _____

Are you taking or have you recently taken any medicine(s), including nonprescription medications? If so, please list each medication, dose, and the correlating diagnosis.

Prescribed: _____

Over-the-counter: _____

Natural or herbal preparations: _____

Do you have any allergies or adverse reactions to any medications or any materials commonly used in a dental office (latex, nickel)? **YES NO**

Please specify: _____

Please continue on reverse side

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Have you received instructions from a physician or dentist to take antibiotics before receiving dental treatment? **YES NO**
 If so, for what reason? _____

Have you ever taken bisphosphonate medication in oral or injected form (drugs such as *Actonel, Fosamax, and Boniva, or Aredia, Bonefos, and Zometa?* **YES NO**

Do you use tobacco? **YES NO** If so, how much? _____ How many years? _____

Do you have any of the following conditions: if you answer "yes" to any of the three items below, please stop and inform the dentist

Active tuberculosis (Tb)	YES	NO
Persistent cough of greater than three weeks duration	YES	NO

Please indicate if you have or have had any of the following diseases or conditions:

Abnormal bleeding AIDS or HIV infection Anemia Arthritis Rheumatoid arthritis Asthma Blisters on lips or mouth Blood transfusion date _____ Cancer treatment: chemotherapy/radiation/surgery Cardiovascular disease Angina pectoris Arteriosclerosis Artificial heart valves Coronary insufficiency (CHF) Coronary occlusion Damaged heart valves Heart attack Heart murmur High blood pressure Inborn heart defects Mitral valve prolapse Rheumatic heart disease	Chest pain upon exertion Chronic pain Persistent diarrhea Disease, drug, or radiation-induced immunosuppression Diabetes Type I (IDDM) Type II (NIDDM) Dry mouth Eating Disorder please specify _____ Epilepsy Fainting spells or seizures GE reflux Glaucoma Headaches, severe or migraine Hemophilia Hepatitis, jaundice, or liver disease Hepatitis Type: _____ Recurrent infections Kidney problems Low blood pressure	Mental health disorders please specify: _____ Malnutrition Neurological disorders please specify: _____ Osteoporosis Persistent swollen glands in neck Respiratory problems Emphysema Bronchitis, etc. Sexually transmitted disease please specify: _____ Sinus trouble Sleep disorder Sores or ulcers in/around mouth Stroke Systemic lupus erythematosus Hyper-/Hypothyroidism Ulcers Excessive urination Weight loss, unexplained Other _____
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SUMMARY (to be completed by dentist)
