PATIENT NAME: _____

HEALTH HISTORY

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

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

SUMMARY (to be completed by dentist)

_____

_____

_____