HEATH HISTORY

Physician's Name: _____

Are you under medical treatment now? ☐ Yes ☐ No

Do you have or have you had any of the following? **** PLEASE MARK YES OR NO FOR EACH ITEM****

Yes	No		Yes	No		Yes	No	
☐	☐	AIDS	☐	☐	Emphysema, COPD	☐	☐	Psychiatric Care
☐	☐	Anemia	☐	☐	Epilepsy or Seizures	☐	☐	Radiation Treatment
☐	☐	Anxiety	☐	☐	Fainting or Fatigue	☐	☐	Respiratory Disease
☐	☐	Arthritis, Osteo, Rheumatism	☐	☐	Glaucoma	☐	☐	Rheumatic Fever
☐	☐	Artificial Heart Valves	☐	☐	Headaches / Migraine	☐	☐	Scarlet Fever
☐	☐	Artificial Joints	☐	☐	Heart Murmur	☐	☐	Shortness of breath
☐	☐	Asthma	☐	☐	Heart Problems	☐	☐	Sinus Trouble
☐	☐	Back Problems	☐	☐	Hepatitis Type _____	☐	☐	Skin Rash
☐	☐	Bipolar disorder	☐	☐	Herpes	☐	☐	Stroke
☐	☐	Bleeding Abnormally	☐	☐	High Blood Pressure	☐	☐	Swelling of Feet/ Ankles
		W/Extractions or Surgery	☐	☐	High Cholesterol	☐	☐	Swollen Neck Glands
☐	☐	Blood Disease	☐	☐	HIV Positive	☐	☐	Thyroid Problems
☐	☐	Cancer	☐	☐	Jaundice	☐	☐	Tonsillitis
☐	☐	Chemical Dependency	☐	☐	Jaw Pain	☐	☐	Tuberculosis
☐	☐	Chemotherapy	☐	☐	Kidney Disease	☐	☐	Tumor/Growth on neck
☐	☐	Circulatory Problems	☐	☐	Liver Disease	☐	☐	Ulcer
☐	☐	Congenital Heart Lesions	☐	☐	Low Blood Pressure	☐	☐	Venereal Disease
☐	☐	Cortisone Treatments	☐	☐	Mitral Valve Prolapse	☐	☐	Weight Loss, unexplained
☐	☐	Cough, persistent/bloody	☐	☐	Nervous Problems	☐	☐	Other: _____
☐	☐	Depression	☐	☐	Pacemaker			_____
☐	☐	Diabetes						_____

Medication Information

LIST ANY MEDICATIONS including non-prescription **Medications** that you are currently taking:

_____
_____
_____
_____
_____

Allergies

☐ Amoxicillin, Penicillin, or other Antibiotics
☐ Aspirin
☐ Barbiturates
☐ Codeine
☐ Iodine
☐ **Latex**
☐ Local Anesthetic (e.g.Novacaine)
☐ Sulfa Drugs
☐ Other _____
_____

Do you use:

☐ Tobacco or Vaping ☐ Alcohol ☐ Other Drugs

Dental History

1. Are you having any discomfort at this time? _____
2. How long since you have been to a dentist? _____
3. Date of last x-rays? _____
4. Have you ever had a permanent tooth extracted? Yes ☐ No ☐ Reason: _____ Complications? _____
5. Was the tooth replaced? _____ If not, why? _____
6. Do you want to keep your remaining natural teeth? _____
7. Are your teeth sensitive to Hot ☐ Cold ☐ Sweets? ☐
8. Have you ever experienced any of the following problems with your jaw?
   ☐ Clicking ☐ Difficulty opening or closing ☐ Sleep apnea ☐ Pain ☐ Difficulty or pain chewing ☐ Snoring
9. Do you clench or grind your teeth? _____ ☐ Night ☐ Day ☐ Both
10. Have you had your teeth straightened? _____ ☐ Braces ☐ Removable Appliance
11. Have you had periodontal (gum) treatments? _____ _____
12. **FOR WOMAN are you pregnant? _____ Due Date ___/___/___ Nursing? _____ Taking Birth Control Pills? _____**