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| **Health and Dental History**Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Appointment Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Nickname:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last First MIParent/Guardian (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Age:\_\_\_\_\_\_\_\_\_ \_\_\_\_Male \_\_\_\_Female \_\_\_ Married \_\_\_Single \_\_\_Child \_\_\_Other**Phone Numbers:***Home:*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Work:\_\_\_\_\_\_\_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HomeAddress:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Health Information**Date of Last Dental Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for Visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are You Currently in Any Dental Pain Right Now? Yes NoIf yes, Please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Have You Ever Had Any Complications During or Following Dental Treatment? Yes NoIf Yes, Please Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are You Unhappy About Your Smile? Yes NoIf Yes, Please Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Have You Had Braces? Yes NoIf Yes, Please List Orthodontist’s Name and Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are You Aware of Having an Allergic Reaction to Any Medication or Substance? Yes NoIf Yes, Please Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do You Smoke or Drink? Yes NoIf Yes, Please Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are You Taking/Using any Recreational Drugs? Yes NoIf Yes, Please Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Have You Been Admitted to the Hospital or Needed Emergency Care During The Past Two Years? Yes NoIf Yes, Please Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are You Taking Birth Control Pills? Yes NoIf Yes, Please Provide Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are you Pregnant, or Trying to Become Pregnant? Yes NoIf Yes, How Many Weeks?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_When is Your Due Date?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are you Nursing? Yes NoAre You now Under The Care of a Physician? Yes NoIf Yes, Please Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are You Taking Any Medications? Yes NoIf Yes, Please List Name And Dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PLEASE LIST ANY MEDICATION YOU MAY BE CURRENTLY TAKING

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| MEDICATION  | DOSAGE  | HOW OFTEN  | ROUTE (ORAL/INJECTION)  | WHAT IS MEDICATION TAKEN FOR?  |
|   |   |   |   |   |
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MEDICAL HISTORY CONTINUED **HAVE YOU EVER EXPERIENCED OR HAD ANY OF THE FOLLOWING? PLEASE** **MARK YES OR NO TO EACH ITEM.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| AIDS/HIV  | □Yes □No  |   | Hepatitis A B C or D  | □Yes □No  |   |   |   |
| Allergies  | □Yes □No  |   | Herpes  | □Yes □No  |
| Anemia  | □Yes □No  |   | High Blood Pressure  | □Yes □No  |
| Arthritis/Rheumatism  | □Yes □No  |   | Hives/Rash  | □Yes □No  |
| Artificial Joints  | □Yes □No  |   | Insomnia/Frequent Waking  | □Yes □No  |
| Artificial Heart Valve  | □Yes □No  |   | Jaundice  | □Yes □No  |
| Asthma  | □Yes □No  |   | Kidney Disease  | □Yes □No  |
| Autism | □Yes □No |   | Liver Disease  | □Yes □No  |
| Back Problems  | □Yes □No  |   | Mental Illness | □Yes □No |
| Bell's Palsy  | □Yes □No  |   | Multiple Sclerosis | □Yes □No |
| Bladder Disease/Problems  | □Yes □No  |   | Nervous Problems  | □Yes □No  |
| Bleeding Problems  | □Yes □No  |   | Prosthetic Heart Valve  | □Yes □No  |
| Blood Transfusions  | □Yes □No  |   | Psychiatric Care  | □Yes □No  |
| Bruise Easily  | □Yes □No  |   | Radiation Treatment  | □Yes □No  |
| Cancer  | □Yes □No  |   | Respiratory Problems  | □Yes □No  |
| Circulatory Problems  | □Yes □No  |   | Rheumatic Fever  | □Yes □No  |
| Chemotherapy  | □Yes □No  |   | Ringing of Ears  | □Yes □No  |
| Chest Pain  | □Yes □No  |   | Sexually Transmitted Disease  | □Yes □No  |
| Crohn’s Disease | □Yes □No |   | Shingles  | □Yes □No  |
| Congested Ears  | □Yes □No  |   | Sickle Cell Disease  | □Yes □No  |
| COPD  | □Yes □No  |   | Sinus Problems  | □Yes □No  |
| Diabetes  | □Yes □No  |   | Skin Rash/Disease  | □Yes □No  |
| Dizziness or Fainting  | □Yes □No  |   | Stomach Problems  | □Yes □No  |
| Down Syndrome | □Yes □No |   | Stroke  | □Yes □No  |
| Epilepsy  | □Yes □No  |   | Surgeries  | □Yes □No  |
| Fibromyalgia | □Yes □No |   | Swelling of the Limbs  | □Yes □No  |
| Glaucoma  | □Yes □No  |   | Thyroid Problems  | □Yes □No  |
| Gout  | □Yes □No  |   | Tingling in Arms/Fingers  | □Yes □No  |
| Headaches  | □Yes □No  |   | Tuberculosis  | □Yes □No  |
| Heart Attack  | □Yes □No  |   | Tumor or Growths  | □Yes □No  |
| Heart Murmur  | □Yes □No  |   | Ulcers  | □Yes □No  |
| Heart Pacemaker  | □Yes □No  |  | Weight Loss/Gain  | □Yes □No  |

Do you have or have you had any disease, condition or problem not listed? Yes No If Yes, Please Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Do any of the Following Dental Concerns Apply to you?**

|  |  |
| --- | --- |
| Bad Breath  | □Yes □No  |
| Bleeding Gums | □Yes □No |
| Blisters on Lips or Mouth  | □Yes □No  |
| Burning Sensation on Tongue  | □Yes □No  |
| Clicking or Popping Jaw and or swollen/tender  | □Yes □No  |
| Clenching or Grinding of Your Teeth  | □Yes □No  |
| Dry Mouth  | □Yes □No  |
| Food Collecting/Packing Between Teeth  | □Yes □No  |
| Lip or Cheek Biting  | □Yes □No |
| Loose or Broken Teeth  | □Yes □No |
| Loose or Broken Fillings/Crowns | □Yes □No  |
| Missing Teeth | □Yes □No  |
| Sensitivity to Pressure or Other: (cold, heat, sweets)  | □Yes □No  |
| Stained/Darker Than Normal Teeth | □Yes □No  |
| Spaces/Gaps Between Teeth | □Yes □No |
| Tooth Ache(s) | □Yes □No |
| Other Dental Concerns (Please List): | □Yes □No |
|  |  |
|  |  |

I have answered all the questions to the best of my knowledge. Should further information be needed, I grant permission to ask my respective healthcare providers or agencies, who may release information to you. I will notify the dentist of any changes in my heath or medication.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Patient, parent, or legal guardian signature Date  |   |  |