HEALTH HISTORY

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name _____ Birthdate _____ Age _____

Why are you seeking dental treatment? _____

Please answer each question. Circle Yes or No. If in doubt, leave it blank.

1. Are you in good health now?..... Yes No
2. Are you now under the care of a physician? ..... Yes No
   If so, what is the condition being treated? _____
3. Have you ever been hospitalized or had a serious illness?..... Yes No
   If yes, explain _____
4. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously? Yes No
5. (Women) Are you pregnant? If so, give due date _____ Yes No
6. Do you use tobacco in any form? If yes, how much? _____ Yes No
7. Do you use alcoholic beverages (more than 2 drinks per day)? ..... Yes No
8. Do you have or have you ever had any of the following?

GENERAL		
Tire easily, weakness	Yes	No
Marked weight change	Yes	No
Night sweats	Yes	No
Persistent fever	Yes	No
SKIN		
Eruptions (rash) hives	Yes	No
Change in skin color	Yes	No
EYES		
Visual Change	Yes	No
Glaucoma	Yes	No
EARS		
Loss of hearing	Yes	No
Ringing in ears	Yes	No
NOSE		
Frequent nosebleeds	Yes	No
Sinus problems	Yes	No
THROAT		
Soreness/hoarseness	Yes	No
NERVOUS SYSTEM		
Stroke	Yes	No
Headaches	Yes	No
Convulsions/epilepsy	Yes	No
Numbness/tingling	Yes	No
Dizziness/fainting	Yes	No
Psychiatric treatment	Yes	No
RESPIRATORY		
Tuberculosis	Yes	No
Emphysema	Yes	No
Asthma	Yes	No
Persistent cough	Yes	No
Sputum production (Phlegm)	Yes	No
Cough up bloody sputum	Yes	No
Difficulty breathing lying down	Yes	No
ENDOCRINE		
Diabetes	Yes	No
Family history of diabetes	Yes	No
Thyroid condition/goiter	Yes	No
Other _____		

HEART/BLOOD VESSELS		
Rheumatic Fever	Yes	No
Heart Murmur	Yes	No
Chest pain/discomfort	Yes	No
Heart attack/trouble	Yes	No
Shortness of breath	Yes	No
High blood pressure	Yes	No
Congenital heart disease	Yes	No
Artificial heart valve	Yes	No
Pacemaker	Yes	No
Heart surgery	Yes	No
Other _____		
BONE/MUSCLES		
Arthritis/rheumatism	Yes	No
Artificial joints	Yes	No
DIGESTIVE SYSTEM		
Hepatitis type___	Yes	No
Jaundice	Yes	No
Ulcers	Yes	No
Change in appetite	Yes	No
Black, bloody or pale stools	Yes	No
URINARY		
Kidney disease	Yes	No
Increase in frequency of urination (night)	Yes	No
Burning on urination	Yes	No
Urethral discharge	Yes	No
Bloody urine	Yes	No
Venereal disease	Yes	No
BLOOD		
Bruise easily	Yes	No
Anemia	Yes	No
Blood transfusion	Yes	No
OTHER		
Radiation therapy	Yes	No
Tumors or growths	Yes	No
Cancer	Yes	No
AIDS	Yes	No
Homeopathic Preparations	Yes	No

Please complete other side

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9. Are you **ALLERGIC** to or have you ever experienced any reaction to the following medications?

Local anesthetics (e.g. Novocain)	Yes	No	Aspirin or Codeine	Yes	No
Barbiturates/sedatives/sleeping pills	Yes	No	Sulfa Drugs	Yes	No
Penicillin	Yes	No	Other Allergies _____		

10. Are you taking any of the following?

Antibiotics/sulfa drugs	Yes	No	Tranquilizers	Yes	No
Blood thinners	Yes	No	Insulin/other diabetes drugs	Yes	No
Blood pressure medication	Yes	No	Recreational drugs	Yes	No
Thyroid medication	Yes	No	Digitalis/other heart medications	Yes	No
Cortisone/steroids	Yes	No	Nitroglycerin	Yes	No
Antihistamines/allergy drugs/			Aspirin	Yes	No
Cold Remedies	Yes	No	Viagra, Cialis, Revatio or any other Vasodilator	Yes	No
Herbal Supplements	Yes	No			

Other _____

If yes to any of the above, list ***name*** of medication and ***dosage*** below:

1. _____
2. _____
3. _____
4. _____

11. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain _____

12. Physician's Name _____ Phone _____

13. Have you ever had any serious trouble associated with previous dental treatment? Yes No
If so, explain _____

14. Does dental treatment make you nervous? No Slightly Moderately Extremely

15. Date of last dental visit _____

16. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? Yes No
If so, when? _____

17. Do you have or have you ever had any of the following?

MOUTH			**TEETH**		
Bleeding, sore gums	Yes	No	Loose teeth	Yes	No
Unpleasant taste/bad breath	Yes	No	Sensitive to hot	Yes	No
Burning tongue/lips	Yes	No	Sensitive to cold	Yes	No
Frequent blister, lips/mouth	Yes	No	Sensitive to sweets	Yes	No
Swelling/lumps in mouth	Yes	No	Sensitive to biting	Yes	No
Ortho treatments (braces)	Yes	No	Food impaction	Yes	No
Biting cheeks/lips	Yes	No	Clenching/grinding	Yes	No
Clicking/popping jaw	Yes	No	Shifting of teeth	Yes	No
Difficulty opening or closing jaw	Yes	No	Change in bite	Yes	No

ORAL HYGIENE

Do you use the following?

Brush	Yes	No	How often do you brush? _____		
Dental floss	Yes	No	Brush is: soft medium hard		
Fluoride rinse	Yes	No			

Other _____

I consent and authorize Advanced Dental Concepts to use photographs, video, slides, or any other image as may be necessary of me, with or without my given name, or with a fictitious name for my treatment, education, or any other lawful purpose and I release and forever discharge it from any claim, demands, or liability on account of such use or for the quality of the reproduction of the photograph or photocopy provided.

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at my next dental appointment.

Signature of patient, parent or guardian _____ **Date** _____