HEALTH HISTORY

To help us ensure your well-being while receiving treatment in our office please answer the following questions.
All information will be considered confidential and for our records only.

PLEASE MARK THE MOST APPROPRIATE ANSWERS. PLEASE EXPLAIN WHEN INDICATED:

hepatitis C
jaundice
liver disease
gastrointestinal disorder
kidney disease
prosthetic joint/heart valve
tested possitive for HIV
tested possitive for AIDS
leukemia
eating disorder
psychiatric disorder
drug and/or alcohol dependency
WOMEN ONLY: Pregnant
WOMEN ONLY: Breastfeeding

Any other medical/health conditions the dentist should know about? _____

_____

Have you ever experienced abnormal bleeding associated with a previous extraction, surgery or trauma?
Yes
Have you ever experienced any unusual reactions to fluoride?
Yes
Have you ever experienced any unusual reactions to local anesthetics?
Yes
Are you happy with the appearance of your teeth?
Yes
How frequently do you brush? _____ How frequently do you floss? _____
Do you have any oral habits such as clenching, grinding, nail biting or thumb sucking?
Yes Kind: _____
Do you use tobacco (smoke/chew)? Frequency: _____ Do you drink alcohol? Frequency? _____
Do you use marijuana? Frequency? _____ Do you use other recreational drugs? _____
Have you been examined and/or treated by a physician in the last year?
Yes
Family doctor: _____ Family doctor phone #: _____
Have you ever been hospitalized?
Yes
Reason: _____
Allergies: _____
When was your last dental visit? _____
What was done? _____
When were your last x-rays taken? _____
Do you have any dental concerns? _____

PLEASE LIST ANY MEDICATIONS *(prescription and over-the-counter)*:

_____ _____

_____ _____

To the best of my knowledge, I certify that all of the preceding answers are true and correct. If I ever have any changes in my health or medications I will inform the doctor or hygienist at the next appointment without fail. I further consent to dental and oral surgery procedures that are agreed to be necessary, including the use of local anesthetic.

_____ _____

PATIENT SIGNATURE **DATE**
(or guardian)