Thank you for taking the time to fill out our updated Health History Form. This helps us treat you with the highest standard of care to meet your dental health needs.

Dental History

Name	Birth date	Today's Date
What would you like us to do today?	Are you in dental discomfort today?	

Check if you have had problems with any of the following:

_Bad Breath	_Food collection btwn teeth	_Periodontal treatment	_Sensitivity to sweets
_Bleeding gums	_Grinding/Clenching teeth	_Sensitivity to cold	_Sensitivity to Biting
_Clicking/popping jaw	_Loose teeth or broken fillings	_Sensitivity to hot	_Sores or growth in mouth

How often do you brush? Floss?

How do you feel about the appearance of your teeth?

Other information about your dental health or previous treatment?

Medical History

Physician's Name	Phone #	Date of last visit
Have you had any serious illnesses or operations?	If Yes, Describe	
Are you currently under physician care?	If Yes, describe	
Have you ever had a blood transfusion?	If Yes, when	
Have you ever taken Fen Phen/Redux?	Have you ever taken Bisphosphonates?	
Are you pregnant?	Nursing?	Taking birth control pills?

Check if you have ever had any of the following;

_AIDS/HIV Positive	_Cough, Persistent	_Jaw pain	_Shingles	Doctor Comments:
_Anaphylaxis	_Cough up blood	_Kidney disease or malfunction	_Shortness of breath	
_Anemia	_Diabetes	_Liver disease	_Skin rash	
_Arthritis, Rheumatism	_Epilepsy	_Material allergies (latex, metal, etc)	_Spina Bifida	
_Artificial heart valves	_Fainting	_Mitral valve prolapse	_Stroke	
_Artificial joints	_Food allergies	_Nervous problems	_Surgical implant	
_Asthma	_Glaucoma	_Pacemaker/ Heart surgery	_Swelling of feet or ankles	
_Atopic (allergy prone)	_Headaches	_Psychiatric care	_Thyroid problems	
_Back problems	_Heart murmur	_Rapid weight gain or loss	_Tobacco habit	
_Blood disease	_Heart problems	_Radiation treatment	_Tonsilitis	
_Cancer	_Hemophilia/ Abnormal bleeding	_Respiratory disease	_Tuberculosis	
_Chemical dependency	_Herpes	_Rheumatic/Scarlet fever	_Ulcer/Colitis	
_Chemotherapy	_Hepatitis		_Venereal disease	
_Circulatory problems	_High blood pressure			
_Cortisone treatments				

Do you have any drug allergies?	If Yes, List:	
Current Pharmacy:	Location	Phone #
Current Medications	Dose	Reason

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status I will inform the dentist.

Signature Date