

### Health History

Reason for Today's Visit: \_\_\_\_\_

Date of last dental visit: \_\_\_\_\_

Former Dentist: \_\_\_\_\_

Phone # \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Phone # \_\_\_\_\_

Have you ever been instructed by any doctor to pre-medicate before dental visits?

yes    no

How often do you floss? \_\_\_\_\_

How often do you brush? \_\_\_\_\_

**Allergies:**    Aspirin    Barbiturates (sleeping pills)    Codeine    Iodine    Latex    Sulfa  
 Local Anesthetic    Penicillin    Other \_\_\_\_\_

**Medications:** \_\_\_\_\_

**Pharmacy Name** \_\_\_\_\_ **Pharmacy #** \_\_\_\_\_

Have you had any of the following:

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> AIDS/HIV</li> <li><input type="checkbox"/> Anemia</li> <li><input type="checkbox"/> Arthritis, Rheumatism</li> <li><input type="checkbox"/> Artificial heart valves</li> <li><input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> Back problems</li> <li><input type="checkbox"/> Bad breath</li> <li><input type="checkbox"/> Bleeding abnormally after extractions</li> <li><input type="checkbox"/> Bleeding gums</li> <li><input type="checkbox"/> Blisters on lips or mouth</li> <li><input type="checkbox"/> Blood disease</li> <li><input type="checkbox"/> Burning sensation on tongue</li> <li><input type="checkbox"/> Cancer</li> <li><input type="checkbox"/> Chemical dependency</li> <li><input type="checkbox"/> Chemotherapy</li> <li><input type="checkbox"/> Chew on one side of mouth</li> <li><input type="checkbox"/> Cigarette, pipe or cigar smoking</li> <li><input type="checkbox"/> Circulatory problems</li> <li><input type="checkbox"/> Clicking or popping of jaw</li> <li><input type="checkbox"/> Congenital heart lesions</li> <li><input type="checkbox"/> Cortisone treatments</li> <li><input type="checkbox"/> Cough, persistent or bloody</li> <li><input type="checkbox"/> Diabetes</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Jaundice</li> <li><input type="checkbox"/> Kidney disease</li> <li><input type="checkbox"/> Lip or cheek biting</li> <li><input type="checkbox"/> Liver disease</li> <li><input type="checkbox"/> Loose teeth or broken fillings</li> <li><input type="checkbox"/> Low blood pressure</li> <li><input type="checkbox"/> Mitral valve prolapse</li> <li><input type="checkbox"/> Mouth breathing</li> <li><input type="checkbox"/> Mouth pain, brushing</li> <li><input type="checkbox"/> Nervous problems</li> <li><input type="checkbox"/> Orthodontic treatment</li> <li><input type="checkbox"/> Pace maker</li> <li><input type="checkbox"/> Pain around ear</li> <li><input type="checkbox"/> Periodontal treatment</li> <li><input type="checkbox"/> Psychiatric care</li> <li><input type="checkbox"/> Radiation treatment</li> <li><input type="checkbox"/> Respiratory disease</li> <li><input type="checkbox"/> Rheumatic fever</li> <li><input type="checkbox"/> Scarlet fever</li> <li><input type="checkbox"/> Sensitivity to cold</li> <li><input type="checkbox"/> Sensitivity to heat</li> <li><input type="checkbox"/> Sensitivity to sweets</li> <li><input type="checkbox"/> Shortness of breath</li> </ul> |
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- Dry mouth
- Emphysema
- Epilepsy
- Fainting or Dizziness
- Fingernail biting
- Food collection between teeth
- Foreign objects in mouth
- Glaucoma
- Grinding teeth
- Growth or tumor on head or neck
- Headaches
- Heart murmur
- Heart problems
- Sinus trouble
- Skin rash
- Sores or growth in mouth
- Special diet
- Stroke
- Swollen feet or ankles
- Swollen neck glands
- Thyroid problems
- Tonsillitis
- Tuberculosis
- Ulcer
- Venereal Disease

**WOMEN:**

- Herpes
- Hepatitis Type \_\_\_\_\_
- Are you pregnant?       yes    no
- Are you nursing?       yes    no
- Taking birth control pills?  yes    no