DENTUS®
A COMMUNITY OF SMILES

Health History Form

Patient Information

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient Name: ______________________________

Date of Birth: ______________________________

Name of your physician: ______________________________

Date of last visit to physician: ______________________________

Name of previous dentist: ______________________________

Date of last visit to dentist: ______________________________

Medical Health History

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING? PLEASE CHECK ALL THAT APPLY.

Heart Problems

- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Blood pressure problems - ☐ Low ☐ High
- ☐ Heart murmur
- ☐ Heart valve problem
- ☐ Taking heart medication
- ☐ Rheumatic fever
- ☐ Pacemaker
- ☐ Artificial heart valve

Blood Problems

- ☐ Easy bruising
- ☐ Frequent nose bleeds
- ☐ Abnormal bleeding
- ☐ Blood disease (anemia)

Intestinal Problems

- ☐ Ulcers

Bone or Joint Problems

- ☐ Arthritis
- ☐ Back or neck pain
- ☐ Joint replacement (e.g., total hip)
- ☐ Pre-med recommended?

Are you allergic or have you reacted adversely to any of the following?

- ☐ Local anesthetic (Novocain)
- ☐ Penicillin or other antibiotics
- ☐ Sulfa drugs
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Aspirin
- ☐ Codeine
- ☐ Iodine
- ☐ Other: ______________________________

Diabetes

- ☐ Urinate more than 6 times per day
- ☐ Thirsty or dry mouth most of the time
- ☐ Family history of diabetes
- ☐ Diet controlled
- ☐ Insulin controlled

- ☐ Fainting spells, seizures, or epilepsy
- ☐ Tuberculosis or other respiratory disease
- ☐ Cancer/tumor
- ☐ Do you drink? How much? ____________________
- ☐ Do you smoke? How much? ____________________
- ☐ Do you chew tobacco?
- ☐ Hepatitis - Type ☐ A ☐ B ☐ C
- ☐ Jaundice or liver trouble
- ☐ Herpes
- ☐ HIV positive/AIDS
- ☐ Glaucoma
- ☐ Do you wear contact lenses?

During the past year have you taken any of the following?

- ☐ Antibiotics or sulfa drugs
- ☐ Anticoagulants (e.g., Coumadin)
- ☐ High blood pressure medicine
- ☐ Tranquilizers
- ☐ Insulin, Orinase, or similar drug
- ☐ Drugs for heart problems
- ☐ Nitroglycerin
- ☐ Cortisone (steroids)
- ☐ Herbal suppliments, diet pills, or vitamins
  Please list: ______________________________
- ☐ Fosamax, Boniva, Actonel, Zometa or any other drug used to treat Osteoporosis
- ☐ Illegal drugs
- ☐ Other: ______________________________
- ☐ (Women): Are you pregnant?

Dental Health History

PLEASE MARK ANY QUESTIONS THAT YOU WOULD ANSWER "YES":

- ☐ Are you apprehensive about dental treatment?
- ☐ Have you had problems with previous dental treatment?
- ☐ Do you gag easily?
- ☐ Does food become lodged easily between your teeth?
- ☐ Do you have difficulty chewing your food?
- ☐ Do you avoid brushing any part of your mouth because of pain?
- ☐ Do your gums bleed easily?
- ☐ Do your gums feel swollen or tender?
- ☐ Have you ever noticed slow-healing sores in or about your mouth?
- ☐ Are your teeth sensitive to:
    - ☐ Hot foods or liquids?
    - ☐ Cold foods or liquids?
    - ☐ Sweets?
    - ☐ Bite pressure?
- ☐ Are you dissatisfied with the appearance of your teeth?
- ☐ Are you seeking comprehensive dental care?
- ☐ Do you brush at least twice a day?
- ☐ Do you floss at least once a day?
- ☐ Do you have pain in the face, cheeks, jaw, joints, throat or temples?
- ☐ Do you clench or grind your jaw frequently; does it "pop" when you open or close your mouth?
- ☐ Does your jaw get stuck so that you can't open freely?
- ☐ Does it hurt when you chew or open wide to take a bite?
- ☐ Do you have any jaw symptoms or headaches upon waking in the morning?
- ☐ Do you take medication or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?
- ☐ Are you unable to open your mouth as far as you want?
- ☐ Have you had any trauma to the jaw?
- ☐ Do you have any disease, condition, or problem not listed previously that you feel we should know about?

If so, please describe: ____

____

Date: ____________ **Reviewed by Dr.** ________________ **Patient Signature:** ______________________________

FOR OFFICIAL USE ONLY: UPDATES

Update______________ Initial _________ Changes ______________________________

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Update______________ Initial _________ Changes ______________________________

Update______________ Initial _________ Changes ______________________________

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