



NAME: _____

DATE OF BIRTH: _____

TODAY'S DATE: _____

DENTAL HEALTH HISTORY

Answer all questions by circling Yes (Y) or No (N)

- 1. Are you in good health? Y N
- 2. Name of your physician? _____
- 3. Date of last physical exam? _____
- 4. Have you ever had any serious illness, hospitalization or surgery? Y N
- 5. Allergies/Sensitivities? _____
- 6. Do you have any disabilities or physical limitations?

- 7. Who is your previous dentist? _____
- 8. When was your last dental visit? _____
- 9. Are you having any dental problems? Y N
- 10. Please list any medications you are currently taking

11. What is your perception of your oral health status?

12. Are you having any specific dental problem?

13. Do you have or have you ever had:

- A. Cardiovascular Disease (Angina, Heart Attack, Heart Murmur, Coronary Artery Disease, High Blood Pressure, Stroke, Palpitations, Pacemaker, Tachycardia, Brachycardia, Heart Surgery)?..... Y N
- B. Congenital Heart Disease? Y N
- C. Rheumatic Fever or Rheumatic Heart Disease? Y N
- D. Kidney Disease? Y N
- E. Liver Disease (Hepatitis, Jaundice)?..... Y N
- F. Lung Disease (Asthma, Emphysema, COPD, Pneumonia, Chest Pain, Bronchitis)? Y N
- G. Cancer, Radiation Treatment or Chemotherapy?..... Y N
- H. Diabetes?..... Y N
- I. Seizures, Epilepsy, or Convulsions? Y N
- J. Mental Illness?..... Y N
- K. Fainting or Dizziness? Y N
- L. Bleeding Disorder (bleed easily) Y N
- M. Sickle Cell Trait/Disease?..... Y N
- N. Stomach problems?..... Y N
- O. HIV? Y N
- P. AIDS? Y N
- Q. Sexually Transmitted Diseases? Y N
- R. Skin Problems? Y N

- S. Implant Surgery (Joint replacement, Heart Valve, etc.)? Y N
- T. Vision, Hearing or Speech Problems Y N
- U. Jaw Joint (pain, discomfort, clicking or popping)? Y N
- V. Autoimmune Disorders (i.e. Lupus, Fibromyalgia)? Y N
- W. Arthritis?..... Y N
- X. Sinus or Nasal Problems?..... Y N
- Y. Alcohol dependency? Y N
- Z. Drug Use? Y N
- AA. Are you Pregnant? Y N
- BB. Are you nursing? Y N
- CC. Are you taking herbal medication? Y N
- DD. Do you use tobacco? Y N

Please list any surgeries you have had.

Please list any additional information that would be useful to the doctor during the delivery of your dental care.

Dentist Notes: _____

Treatment authorization:

I certify that I have read and understood this form. I certify that all the information regarding my medical history or conditions is accurate.

Patient Signature or Parent/Signature

Date

Dentist Signature

