FAMILYFIRST HEALTH

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

_____

_____

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_____

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.

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_____

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

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_____

Dentist Notes: _____

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_____

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