# Your Health Information

***Your mouth is the window to the rest of your health.***
***Having a complete medical and dental history gives us a clearer view.***
***Thanks for your help in providing this information!***

HILL COUNTRY DENTAL ASSOCIATES

**Today's Date:** _____

**Patient Name:** **Birth Date:**

| | |
|---|---|
| **Personal Physician:** | **Phone:** |
| **Emergency Contact:** | **Phone:** |

**What are your immediate dental concerns?** _____

_____

**Are you allergic to any of the following?**

○ Latex ○ Penicillin ○ Codeine ○ Aspirin ○ Local Anesthetics ○ Acrylic ○ Metals ○ Sulfa Drugs

**Do any of the following conditions apply to you?**

| | | | |
|---|---|---|---|
| Heart Disease/Heart Attack | ○YES ○NO | Cancer | ○YES ○NO |
| Artificial Heart Valve/Pacemaker | ○YES ○NO | HIV Positive, AIDS | ○YES ○NO |
| Hepatitis/Jaundice/Liver Disease | ○YES ○NO | Artificial Joints | ○YES ○NO |
| Bleeding Problems/Anemia | ○YES ○NO | Gastric Reflux/GERD/Ulcers | ○YES ○NO |
| Stroke | ○YES ○NO | Diabetes | ○YES ○NO |
| Drug/Alcohol Addiction | ○YES ○NO | Arthritis/Rheumatoid Arthritis | ○YES ○NO |
| Thyroid Problems | ○YES ○NO | Rheumatic Fever | ○YES ○NO |
| Fainting Spells, Seizures | ○YES ○NO | Rheumatic Heart Disease | ○YES ○NO |
| High or Low Blood Pressure | ○YES ○NO | Could you be/are you pregnant? | ○YES ○NO |
| Osteoporosis | ○YES ○NO | Are you nursing? | ○YES ○NO |
| Tuberculosis, Respiratory Problems | ○YES ○NO | Tobacco Use | ○YES ○NO |
| Asthma | ○YES ○NO | Mouth Ulcers, Fever Blisters | ○YES ○NO |
| Use of Redux or Fen-Phen | ○YES ○NO | Herpes | ○YES ○NO |
| Psychiatric Care | ○YES ○NO | Seasonal Allergies/Sinus Issues | ○YES ○NO |

Have you used any bisphosphonate drugs for treatment of osteoporosis or cetain types of cancer?

○Fosamax ○Actonel ○Atelvia ○Didronel ○Boniva ○Boniva IV ○Reclast ○Prolia

Have you been hospitalized in the past 5 years? ○ YES ○ NO

If YES, why? _____

**Signature:** _____ ***Please Continue on the Next Page*** ➡

# Your Health Information *(Continued)*

**Patient Name:** **Date:**

| **Have you noticed:** | |
|---|---|
| Severe or Chronic Headaches | ○ YES ○ NO |
| Popping/Clicking/Grating in Either Jaw Joint | ○ YES ○ NO |
| Pain or Soreness in Either Jaw Joint | ○ YES ○ NO |
| Bleeding Gums | ○ YES ○ NO |
| Halitosis (Bad Breath) | ○ YES ○ NO |
| Frequent Dry Mouth | ○ YES ○ NO |
| Frequent Daytime Sleepiness | ○ YES ○ NO |

| **When you smile:** | |
|---|---|
| Do you like the color of your teeth? | ○ YES ○ NO |
| Do you like the brightness of your teeth? | ○ YES ○ NO |
| Do you like the shape of your teeth? | ○ YES ○ NO |
| Do you like the alignment of your teeth? | ○ YES ○ NO |
| Do you have fillings that show? | ○ YES ○ NO |
| Is there anything you wish you could change about your smile? | ○ YES ○ NO |

If YES, please what would it be? _____

**Please list any medications, vitamins, and supplements you're currently taking.**
**Continue on the back if more space is needed.**
***(If you have an up-to-date written list, we're happy to make a copy it for you.)***

| **Medications** | | **Vitamins/Supplements** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Signature:** _____