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!

Today's Date: ____________

Patient Name: **Birth Date:**

Personal Physician:	**Phone:**
Emergency Contact:	**Phone:**

What are your immediate dental concerns? ____

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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?

Condition		Condition	
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: ______________________________