

# HEALTH HISTORY

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Why are you now seeking dental treatment? \_\_\_\_\_

Please answer each question. Circle yes or no. If in doubt, leave blank.

1. Are you in good health now?..... Yes No
2. Are you now under the care of a physician? ..... Yes No  
If so, what is the condition being treated? \_\_\_\_\_
3. Have you ever been hospitalized or had a serious illness?..... Yes No  
If yes, explain \_\_\_\_\_
4. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously? Yes No
5. (Women) Are you pregnant? If so, give due date \_\_\_\_\_ Yes No
6. Do you use tobacco in any form? If yes, how much? \_\_\_\_\_ Yes No
7. Do you use alcoholic beverages (more than 2 drinks per day)? ..... Yes No
8. Do you have or have you ever had any of the following?

## GENERAL

Tire easily, weakness Yes No  
 Marked weight change Yes No  
 Night sweats Yes No  
 Persistent fever Yes No

## SKIN

Eruptions (rash) hives Yes No  
 Change in skin color Yes No

## EYES

Visual Change Yes No  
 Glaucoma Yes No

## EARS

Loss of hearing Yes No  
 Ringing in ears Yes No

## NOSE

Frequent nosebleeds Yes No  
 Sinus problems Yes No

## THROAT

Soreness/hoarseness Yes No

## NERVOUS SYSTEM

Stroke Yes No  
 Headaches Yes No  
 Convulsions/epilepsy Yes No  
 Numbness/tingling Yes No  
 Dizziness/fainting Yes No  
 Psychiatric treatment Yes No

## RESPIRATORY

Tuberculosis Yes No  
 Emphysema Yes No

Asthma/hay fever Yes No  
 Persistent cough Yes No  
 Sputum production (Phlegm) Yes No  
 Cough up bloody sputum Yes No  
 Difficulty breathing lying down Yes No

## ENDOCRINE

Diabetes Yes No  
 Family history of diabetes Yes No  
 Thyroid condition/goiter Yes No  
 Other \_\_\_\_\_

## HEART/BLOOD VESSELS

Rheumatic Fever Yes No  
 Heart Murmur Yes No  
 Chest pain/discomfort Yes No  
 Heart attack/trouble Yes No  
 Shortness of breath Yes No  
 High blood pressure Yes No  
 Congenital heart disease Yes No  
 Artificial heart valve Yes No  
 Pacemaker Yes No  
 Heart surgery Yes No  
 Other \_\_\_\_\_

## BONE/MUSCLES

Arthritis/rheumatism Yes No  
 Artificial joints Yes No

## DIGESTIVE SYSTEM

Hepatitis Yes No  
 Jaundice Yes No  
 Ulcers Yes No  
 Change in appetite Yes No  
 Black, bloody or pale stools Yes No

## URINARY

Kidney disease Yes No  
 Increase in frequency of urination (night) Yes No  
 Burning on urination Yes No  
 Urethral discharge Yes No  
 Bloody urine Yes No  
 Venereal disease Yes No

## BLOOD

Bruise easily Yes No  
 Anemia Yes No  
 Blood transfusion Yes No

## OTHER

Radiation therapy Yes No  
 Tumors or growths Yes No  
 Cancer Yes No  
 AIDS Yes No

Please complete second page

9. Are you ALLERGIC or have you ever experienced any reaction to the following?

Local anesthetics (e.g. Novocain)	Yes	No	Aspirin or codeine	Yes	No
Barbiturates/sedatives/sleeping pills	Yes	No	Sulfa drugs	Yes	No
Penicillin/other antibiotics	Yes	No	Other allergies _____		

10. Are you taking any of the following?

Antibiotics/sulfa drugs	Yes	No	Tranquilizers	Yes	No
Blood thinners	Yes	No	Insulin/other diabetes drugs	Yes	No
Blood pressure medication	Yes	No	Recreational drugs	Yes	No
Thyroid medication	Yes	No	Digitalis/other heart medications	Yes	No
Cortisone/steroids	Yes	No	Nitroglycerin	Yes	No
Antihistamines/allergy drugs/ cold remedies	Yes	No	Aspirin	Yes	No
			Other medication _____		

If yes to any of the above, list **name** of medication and **dosage** below:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

11. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain \_\_\_\_\_

12. Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

13. Have you ever had any serious trouble associated with previous dental treatment? Yes No  
If so, explain \_\_\_\_\_

14. Does dental treatment make you nervous? No Slightly Moderately Extremely

15. Date of last dental visit \_\_\_\_\_

16. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? Yes No  
If so, when? \_\_\_\_\_

17. Do you have or have you ever had any of the following?

**MOUTH**

Bleeding, sore gums	Yes	No
Unpleasant taste/bad breath	Yes	No
Burning tongue/lips	Yes	No
Frequent blister, lips/mouth	Yes	No
Swelling/lumps in mouth	Yes	No
Ortho treatments (braces)	Yes	No
Biting cheeks/lips	Yes	No
Clicking/popping jaw	Yes	No
Difficulty opening or closing jaw	Yes	No

**TEETH**

Loose teeth	Yes	No
Sensitive to hot	Yes	No
Sensitive to cold	Yes	No
Sensitive to sweets	Yes	No
Sensitive to biting	Yes	No
Food impaction	Yes	No
Clenching/grinding	Yes	No
Shifting of teeth	Yes	No
Change in bite	Yes	No

**ORAL HYGIENE**

Do you use the following?

Brush	Yes	No
Dental floss	Yes	No
Fluoride rinse	Yes	No
Other _____		

How often do you brush \_\_\_\_\_  
Brush is: soft medium hard

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To the best of my knowledge, all of the preceding answers are true and correct.

If I ever have any change in my health or change in my medication, I will inform the dentist at my next dental appointment.

Signature of patient, parent or guardian \_\_\_\_\_ Date \_\_\_\_\_