

# HEALTH HISTORY

It is important that we know about your dental and medical history. Many things have a direct bearing on your dental health. I will review the questionnaire and discuss it with you in detail. Information you give me is confidential and will not be released to anyone without your written permission.

*For Clinic Use:*

BP: \_\_\_\_\_ P: \_\_\_\_\_

**Do you have or have you had any of the following? Please mark all that apply.**

<i>General</i>	<b>YES</b>	<i>Urinary/Liver</i>	<b>YES</b>	<i>Dental history</i>
Tire easily, weakness	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<b>Does dental treatment make you nervous? (circle)</b> No Slightly Moderate Severe
Marked weight change	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	
Persistent fever	<input type="checkbox"/>	Burning on urination	<input type="checkbox"/>	
<i>Skin</i>		Untreated sexually transmitted disease	<input type="checkbox"/>	<b>Do you have any of the following?</b>
Hives, Rash	<input type="checkbox"/>	Hepatitis A B C	<input type="checkbox"/>	
Any recent noticeable skin changes	<input type="checkbox"/>			Bad breath
<i>Eyes</i>		<i>Blood</i>		Burning lips/Tongue
Glaucoma	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>	Oral swelling or lumps
<i>Ears</i>		Anemia	<input type="checkbox"/>	Frequent fever blisters/cold sores
Loss of hearing	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	Frequent canker sores
Ringing in ears	<input type="checkbox"/>	<i>Other</i>		Biting cheeks/lips
<i>Nose</i>		Cancer	<input type="checkbox"/>	TMJ
Sinus infections	<input type="checkbox"/>	Cancer of/in Bone	<input type="checkbox"/>	Clicking/popping jaw
Sinus problems	<input type="checkbox"/>	Tumors or growths	<input type="checkbox"/>	Difficulty opening or closing jaw
<i>Nervous system</i>		Radiation therapy	<input type="checkbox"/>	Loose teeth
Stroke	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	Teeth sensitive to cold
Headaches	<input type="checkbox"/>	HIV positive	<input type="checkbox"/>	Teeth sensitive to hot
Convulsions/Epilepsy	<input type="checkbox"/>	<i>Allergies to:</i>		Teeth sensitive to sweets
Dizziness/Fainting	<input type="checkbox"/>	Local anesthetics	<input type="checkbox"/>	Areas of food impaction
<i>Osteoporosis/Osteopenia</i>		Sedatives/Sleeping pills	<input type="checkbox"/>	Shifting of teeth
Previous/Current Drug Treatment	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	Noticeable change in your bite
<i>Respiratory</i>		Other antibiotics	<input type="checkbox"/>	Sensitivity when biting
Tuberculosis	<input type="checkbox"/>	Codeine	<input type="checkbox"/>	Have you ever been treated for gum disease?
Emphysema	<input type="checkbox"/>	Sulfa drugs	<input type="checkbox"/>	Have you had gum surgery
Asthma	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<b>Oral hygiene</b>
Hay fever	<input type="checkbox"/>	<b>Are you taking any of the following?</b>		<b>Which do you use daily?</b>
Cough up bloody sputum	<input type="checkbox"/>	Prescription medications	<input type="checkbox"/>	Brush
Difficulty breathing while reclining	<input type="checkbox"/>	Non-prescription medications	<input type="checkbox"/>	Floss
COPD	<input type="checkbox"/>	Herbal medicine	<input type="checkbox"/>	Interdental/Proxabrush
<i>Endocrine</i>		Recreational drugs	<input type="checkbox"/>	Electric toothbrush
Diabetes Type 1 Type 2	<input type="checkbox"/>	<b>List medications below</b>		Mouthwash
Family history of Diabetes	<input type="checkbox"/>	1. _____		<b>Are you happy with the appearance of your teeth? (circle) Yes No</b>
Thyroid condition	<input type="checkbox"/>	2. _____		To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or change in my medication, I will inform my doctor at the next appointment.
<i>Heart/Blood Vessels</i>		3. _____		
Heart Murmur	<input type="checkbox"/>	4. _____		X _____ Signature of Patient/Parent/Guardian
High blood pressure	<input type="checkbox"/>			
Heart attack	<input type="checkbox"/>	<b>Do you consume more than two alcoholic beverages per day?</b>	<input type="checkbox"/>	Date _____
Heart surgery	<input type="checkbox"/>	<b>Have you used tobacco products?</b>	<input type="checkbox"/>	
Artificial heart valve	<input type="checkbox"/>	<b>Do you currently use tobacco products?</b>	<input type="checkbox"/>	
Pacemaker	<input type="checkbox"/>	Type/Amt: _____	<input type="checkbox"/>	
Atrial Fibrillation	<input type="checkbox"/>	<b>Are you pregnant?</b>	<input type="checkbox"/>	
Chest pain/Angina	<input type="checkbox"/>	Due date: _____	<input type="checkbox"/>	
Congenital heart disease	<input type="checkbox"/>	<b>Have you ever been told you cannot donate blood?</b>	<input type="checkbox"/>	
Rheumatic fever	<input type="checkbox"/>			
<i>Musculoskeletal System</i>				
Bone/Muscles	<input type="checkbox"/>			
Arthritis/rheumatism	<input type="checkbox"/>			
Artificial joints/limbs	<input type="checkbox"/>			
<i>Digestive System</i>				
Ulcers	<input type="checkbox"/>			

**Authorization**

DR SIG: X \_\_\_\_\_

Date: \_\_\_\_\_

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance and an additional late fee (\$5) if bill is not paid on time.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Payment is due in full at time of treatment unless prior arrangements have been approved.