Patient Health History

Part I: Dental Concerns

Please check all that you are concerned about or currently have. If none apply, please check "None of the above".

Focus on Overall Objective
__ Comprehensive evaluation
__ Limited exam
__ Keeping my teeth
__ None of the above

Cleaning and Gum Disease
__ Bad breath
__ Gum disease
__ Loose teeth
__ Bleeding gums
__ None of the above

Dentures and Implants
__ Old dentures – don't like
__ Existing dentures loose
__ Collapsed face
__ Can't chew with dentures
__ None of the above

Cosmetics
__ Do not like my smile
__ Have dark/stained teeth
__ Want whiter smile
__ Space/gaps between teeth
__ Dark lines around crowns
__ Crooked teeth
__ None of the above

Jaw/Bite/Orthodontics
__Jaw joint, noise or clicking
__ Pain in jaw, face or neck
__ Headaches
__ Ear pain
__ Teeth wearing down
__ None of the above

Teeth and Fillings
__ Broken fillings
__Broken teeth
__ Sensitive teeth
__ Toothache
__ Dark fillings
__ Tooth decay
__ None of the above

Sleep Issues
__ Hate CPAP – Intolerant
__ Snoring or sleep Apnea
__ Excessive daytime tiredness
__ None of the above

Other
__ Amalgam/Mercury fillings
__ Dry mouth
__ None of the above

Part II: Medication, Supplements, & Surgeries

Please check all that apply. If none apply, please check "None of the above".

1. Do you take or had any of the following:
__ Breathing medications
__ Antidepressants or sleeping pills
__ Aspirin or blood thinners
__ Dilantin or seizure medications
__ Immunosuppressants
__ Calcium channel blockers
__ Previous infective endocarditis
__ Congenital heart disease
__ Total joint replacement
__ None of the above

2. Do you have any allergies or reactions to the following:
__ Hay fever or sinus problems
__ Latex/rubber sensitivity
__ Aspirin
__ Penicillin or another antibiotic
__ Codeine or other pain medications
__ Metals
__ Sulfa drugs
__ Epinephrine
__ Other: ___________________________

3. Has a health care provider recommended that you take antibiotics prior to your dental appointments?
YES **NO**

4. Have you ever taken any bisphosphates or antiresorptive medications for osteoporosis, such as Fosamax, Actonel, Atelvia, Aredia, Zometa, xGEVA, Didronel, Boniva, Reclast or Prolia? **YES** **NO**

5. Please list any prescriptions medications and supplements taken and the reason why.
____
____
____
____
____

6. Please list any surgeries and the dates.

____
____
____
____

Part III:

Please check all that you are concerned about or currently have. If none apply, please check "None of the above".

Cardiovascular

__ Heart murmur/damaged heart valve
__ Heart stent or angioplasty
__ Heart attack
__ Stroke
__ Angina, chest pain or discomfort
__ Congestive heart failure
__ Peripheral artery disease (PAD)
__ Swollen ankles
__ Bleeding/clotting problems
__ High blood pressure
__ High cholesterol
__ Irregular or rapid heartbeat
__ Heart pacemaker
__ None of the above

Endocrine Disorders

__ Thyroid problems
__ Pituitary or adrenal problems
__ Insulin resistant / Pre-diabetics
__ Diabetes – Type 1 (insulin dependent)
__ Diabetes – Type 2 (diet/oral meds)
__ Diabetes – Type 2 (Insulin dependent)
__ Diabetes is controlled
__ None of the above

Cancer

__ Cancer or tumor, oral cancer
__ Chemotherapy or radiation therapy
__ HPV positive (Human Papilloma)
__ Sores/Ulcers 2+ weeks in duration
__ Excessive sun exposure
__ None of the above

ENT – Head & Neck

__ Headache (migraine or tension)
__ Limited mouth opening
__ Jaw, face, neck or back pain
__ Ear problems or pain
__ Mouth breather
__ Hay fever or sinus problems
__ Poor sleep
__ Daytime tiredness
__ Persistent sore throat/chronic cough
__ Chronic hoarseness
__ Unexplained numbness or pain
__ Difficulty chewing
__ Mouth sores 2+ weeks in duration
__ Dentures with persistent sores
__ Difficulty swallowing
__ Difficulty moving jaw or tongue
__ Lump, swelling in mouth or neck
__ Numb mouth or tongue
__ None of the above

Sleep

__ Snoring
__ Daytime tiredness
__ Poor sleep
__ Gasp or stop breathing during sleep
__ Large or thick neck
__ Obstructive sleep apnea
__ CPAP
__ Oral sleep appliance
__ Not currently using any therapy
__ None of the above

Other Diseases & Conditions

__ Liver disease or hepatitis
__ Tuberculosis
__ AIDS / HIV positive
__ Venereal disease / STDs
__ Chronic fatigue / fibromyalgia
__ Arthritis or rheumatism
__ Kidney disease
__ Osteoporosis (bone loss)
__ Acid reflux / Heartburn (GERD)
__ Frequent nausea / vomiting
__ Gastrointestinal disease
__ Ulcers, colitis or irritable bowel
__ Lung disease
__ Asthma
__ Emphysema or COPD
__ Epilepsy or Seizures
__ Memory problems
__ High stress or anxiety
__ Dental phobia / Fear
__ Depression
__ Immune system disorders
__ Sjogren's syndrome
__ Any bleeding disorders
__ History of recreational drug use

Gender Health

Female:
__ Birth control pills
__ Pregnant or planning pregnancy
__ Nursing mother

Male:
__ Erectile dysfunctions

Do you have any disease, condition or problem not listed? ____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner.
I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

______________________________	______________	________________________	______________
Patient/Guardian Signature	Date	Dentist Signature	Date