Name: _____

HEALTH HISTORY

(This information is necessary for our files and will be considered CONFIDENTIAL)

1. How would you describe your general health? [ ] Poor [ ] Fair [ ] Good [ ] Excellent
2. When was your last physical exam? _____month/year Reason: _____
3. Are you now under the care of a physician? [ ] Yes [ ] No Reason: _____
   Physician's Name _____ Phone # (_____) _____
   Address _____
4. Have you been hospitalized or had a serious illness within the past 5 years? [ ] Yes [ ] No
   Reason: _____
5. Are you now taking any medications, drugs, or pills? [ ] Yes [ ] No
   Please List: _____ Reason: _____
6. Do you have, or have you had, any of the following? Please check Yes or No.

Yes	No		Yes	No		Yes	No	
[ ]	[ ]	heart disease	[ ]	[ ]	hepatitis	[ ]	[ ]	are you an alcoholic?
[ ]	[ ]	heart attack (Date_____)	[ ]	[ ]	jaundice	[ ]	[ ]	psychiatric treatment
[ ]	[ ]	heart murmur	[ ]	[ ]	liver disease	[ ]	[ ]	tumor history
[ ]	[ ]	mitral valve prolapse	[ ]	[ ]	kidney disease	[ ]	[ ]	ulcers
[ ]	[ ]	cardiac pacemaker	[ ]	[ ]	anemia	[ ]	[ ]	diabetes (sugar in blood)
[ ]	[ ]	prosthetic heart valve	[ ]	[ ]	blood disorder	[ ]	[ ]	herpes (cold sores)
[ ]	[ ]	heart surgery (Date ____)	[ ]	[ ]	excessive bleeding	[ ]	[ ]	fainting spells
[ ]	[ ]	Rheumatic heart disease	[ ]	[ ]	venereal disease (syphilis, gonorrhea)	[ ]	[ ]	epilepsy
[ ]	[ ]	Rheumatic fever	[ ]	[ ]	cancer (what kind_____)	[ ]	[ ]	blood transfusions (Date___)
[ ]	[ ]	high blood pressure	[ ]	[ ]	radiation treatment (Area _____)	[ ]	[ ]	arthritis (sore/swollen joints)
[ ]	[ ]	low blood pressure	[ ]	[ ]	sinus trouble	[ ]	[ ]	tuberculosis
[ ]	[ ]	hives or rashes	[ ]	[ ]	glaucoma	[ ]	[ ]	respiratory disease
[ ]	[ ]	asthma	[ ]	[ ]	thyroid disease	[ ]	[ ]	ARC
[ ]	[ ]	emphysema	[ ]	[ ]	stroke (Date_____)	[ ]	[ ]	HIV-Positive
[ ]	[ ]	scarlet fever	[ ]	[ ]	steroids (Date_____)	[ ]	[ ]	Artificial Joints(Where_____)

7. Have you ever taken Bisphosphonates for bone density?? [ ] Yes [ ] No If yes, when_____ For how long? _____
8. Do you or did you smoke? [ ] Yes [ ] No If yes, how long? _____ Quit?_____ Date_____
9. Do you chew tobacco? [ ] Yes [ ] No If yes, how long? _____ Quit?_____ Date_____
9. Are you allergic or have you reacted adversely to any of the following? Please check Yes or No.

Yes	No		Yes	No		Yes	No	
[ ]	[ ]	aspirin	[ ]	[ ]	penicillin	[ ]	[ ]	novocaine
[ ]	[ ]	codeine	[ ]	[ ]	tetracycline	[ ]	[ ]	local anesthetic
[ ]	[ ]	valium	[ ]	[ ]	sulfa drugs	[ ]	[ ]	sleeping pills
[ ]	[ ]	nitrous oxide	[ ]	[ ]	erythromycin	[ ]	[ ]	iodine
[ ]	[ ]	barbiturates	[ ]	[ ]	other antibiotics	[ ]	[ ]	latex

10. Are you aware of being allergic to any other medication or substance? [ ] Yes [ ] No
    If yes, please list all: _____
11. Have you ever had excessive bleeding that required treatment? [ ] Yes [ ] No Date_____
12. Has anyone in your family had diabetes? [ ] Yes [ ] No Relationship_____
13. For WOMEN only: Are you pregnant? [ ] Yes [ ] No What Month? _____
    Are you using birth control pills, implants or shots? [ ] Yes [ ] No
14. Do you have any disease, condition or problem not listed above that you think we should know about?
    [ ] Yes [ ] No If yes, please explain_____
    _____
15. Do you play any sports? Please list _____

DENTAL HISTORY

1. Is this the first time you have ever visited a dentist? [ ] Yes [ ] No
2. Reason for this visit: [ ] complete exam [ ] pain [ ] broken tooth [ ] other _____
3. Previous dentist_____ Reason for leaving _____
   Address _____
4. Date of last dental visit _____mo/yr Reason: _____
   Date of last teeth cleaning _____mo/yr Date of last x-rays _____ mo/yr
5. Is it important to you to keep your teeth? [ ] Yes [ ] No
6. Are you satisfied with the appearance of your teeth? [ ] Yes [ ] No
7. Have you ever experienced any of the following? Please check Yes or No.

Yes	No		Yes	No	
[ ]	[ ]	bleeding, painful gums	[ ]	[ ]	clenching or grinding of teeth
[ ]	[ ]	teeth loose	[ ]	[ ]	frequent/unexplained headaches
[ ]	[ ]	food catches between teeth	[ ]	[ ]	pain in joint, ear, side of face
[ ]	[ ]	bad breath or taste in your mouth	[ ]	[ ]	difficulty in opening/closing jaw
[ ]	[ ]	gum treatment	[ ]	[ ]	difficulty in chewing
[ ]	[ ]	braces	[ ]	[ ]	clicking of jaw [ ] Right [ ] Left
[ ]	[ ]	mouth breathing while asleep or awake	[ ]	[ ]	mouthguard or night guard
[ ]	[ ]	teeth sensitive to [ ] hot [ ] cold [ ] sweets [ ] biting			

8. Does dental treatment ever make you nervous? [ ] No [ ] Slightly [ ] Moderately[ ] Severely
9. Have you ever had an upsetting experience in the dental office? [ ] Yes [ ] No
   Explain: _____
10. Is there anything else about having dental treatment that bothers you? [ ] Yes [ ] No
    Explain: _____
11. Would you like to be presedated? (i.e., Xanax) [ ] Yes [ ] No
12. Would you like to use nitrous oxide? (laughing gas) [ ] Yes [ ] No

CHILDREN

13. Do you suck on your finger or thumb? [ ] Yes [ ] No

CONSENT

I give permission to you and your staff to administer anesthetics, to remove any tissue and/or structure and to employ such operative and technical procedures, including x-rays study models, photographs, or any other diagnostic aids as are necessary or advisable for the diagnosis and treatment of the above named patient. I understand that the use of anesthetic agents can be a risk to my health.

During treatment I will immediately report any change in my health to the Doctor before any further dental treatment is performed. I will tell the Doctor if I have been hospitalized consulted a physician,, been sick, or have taken or am taking any new drug or medication in addition to those already reported on my medical history.

Signature:_____ Date: _____