Patient's name: _	

HEALTH HISTORY

As required by our law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable law. This office doesn't use this information to discriminate.

Physician	discriminate.		
Physician Date of Last Exam Are you under medical treatment now? Yes No within the last 5 years? Yes No within the last 5 years? Yes No medications containing bisphosphonates? Yes No medications containing bisphosphonates? Yes No pour use tobacco? Yes No pour use controlled substances? Yes No have you ever taken Fosamax, Boniva, Actoner or any cancer Yes No medications containing bisphosphonates? Yes No pour use controlled substances? Yes No pour use pour use tobacco? Yes No pour use pour us			
Date of Last Exam			
Are you under medical treatment now? Have ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain Have you ever taken Fen-Phen/Redux? Have you ever taken Fosamax, Boniva, Actoner or any cancer medications containing bisphosphonates? Do you use tobacco? Do you use controlled substances? High blood pressure Heart Disease Heart Murmur Swollen Ankles Angina Cancer Requested Frequently Tired Asthma Anemia Emphysema Diabetes Fainting/Seizures Leukemia Arthritis Fainting/Seizures Leukemia Arthritis Fainting/Seizures Leukemia Arthritis Sepully Transmitche Disease Stomach Troubles/Ulcers Acid Reflex Joint Replacement/Implant Chest Pains Easily wounded Hay Fever/Allergies Tuberculosis Stroke Recent Weight Loss Heart Trouble Respiratory Problem Mitral Valve Prolapse Other Dental History No No Yes No No Tyes No No Pental History No If yes, please list the medication(s) including non-prescription medicine? Yes No If yes, please list the medication(s) including non-prescription medicine? Yes No Jo you reent sensitive to hot or cold or pressure or sweets? Yes No 2. Are your teeth sensitive to hot or cold or pressure or sweets? Yes No 2. Are your teeth sensitive to hot or cold or pressure or sweets? Yes No 3. Does your mouth feel dry? 4. Do you have any sores or lumps in or near your mouth?		Of	ffice Phone
Have ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain Have you ever taken Fen-Phen/Redux? Have you ever taken Fosamax, Boniva, Actoner or any cancer medications containing bisphosphonates? Do you use tobacco? Do you use tobacco? High blood pressure Heart Disease Heart Murmur Swollen Ankles Angina Cancer Frequently Tired Asthma Anemia Low Blood Pressure Emphysema Diabetes Fainting/Seizures Leukemia Arthritis Epilepsy/Convulsions Osteoporosis Kidney Disease Hepattis/Jaundice AIDS/HIV Infection Thyroid Problem Sexually Transmitted Disease Stomach Troubles/Ulcers Acid Reflex Joint Replacement/Implant Chest Pains Easily wounded Hay Fever/Allergies Tuberculosis Stroke Radiation Therapy Liver Disease Glaucoma Recent Weight Loss Heart Trouble Respiratory Problem Mitral Valve Prolapse Other Pental History No Dental History No Do you gums bleed while brushing or flossing? Lake Do you gums bleed while brushing or pressure or sweets? Yes No Do you feel about your smile? Pen No Do you feel pain in any of your teeth? So Do you have any sores or lumps in or near your mouth? Yes No Do you have any sores or lumps in or near your mouth? Yes No			
Within the last 5 years? If yes, please explain Have you ever taken Fen-Phen/Redux? Have you ever taken Fosamax, Boniva, Actoner or any cancer			
Have you ever taken Fen-Phen/Redux? Have you ever taken Fosamax, Boniva, Actoner or any cancer medications containing bisphosphonates? Do you use tobacco? Do you use controlled substances? Have you ever had any of the following? High blood pressure Heart Disease Cardiac Pacemaker Rheumatic Fever Heart Murmur Swollen Ankles Angina Cancer Frequently Tired Asthma Low Blood Pressure Emphysema Diabetes Fainting/Seizures Leukemia Epilepsy/Convulsions Osteoporosis Hepatitis/Jaundice Sexually Transmitted Disease Hepatitis/Jaundice Sexually Transmitted Disease Hay Fever/Allergies Tuberculosis Radiation Therapy Liver Disease Radiation Therapy Liver Disease Mittral Valve Prolapse Mittral Valve Prolapse Dien Detail History No Pental History No Dental History No Does your mouth feel dry? Low Dour gour hour bet or read or pressure or sweets? Yes No Yes No No Yes No No Pessure Yes No Yes No Osteoporosis Stroke Glaucoma Recent Weight Loss Heart Trouble Respiratory Problem No No Pental History No Osteoporosis No		ny surgical operation or serio	ous illness Yes No
Have you ever taken Fen-Phen/Redux? Have you ever taken Fosamax, Boniva, Actoner or any cancer yes No medications containing bisphosphonates? Do you use tobacco? Do you use controlled substances? High blood pressure Heart Disease Heart Attack Have you ever had any of the following? High blood pressure Heart Disease Heart Murmur Swollen Ankles Anglina Cancer Frequently Tired Asthma Anemia Low Blood Pressure Emphysema Diabetes Fainting/Seizures Leukemia Arthritis Epilepsy/Convulsions Osteoporosis Kidney Disease Hearting/Seizures AlDS/HIV Infection Thyroid Problem Sexually Transmitted Disease Stomach Troubles/Ulcers Acid Reflex Joint Replacement/Implant Chest Pains Easily wounded Hay Fever/Allergies Tuberculosis Stroke Radiation Therapy Liver Disease Glaucoma Recent Weight Loss Heart Trouble Respiratory Problem Mitral Valve Prolapse Other Are you taking any medication(s) including non-prescription medicine? Yes No If yes, please list the medication(s):			
Have you ever taken Fosamax, Boniva, Actoner or any cancer medications containing bisphosphonates? Do you use tobacco? Do you use controlled substances? High blood pressure Heart Disease Cardiac Pacemaker Rheumatic Fever Heart Murmur Swollen Ankles Low Blood Pressure Emphysema Low Blood Pressure Emphysema Diabetes Fainting/Seizures Leukemia Arthritis Epilepsy/Convulsions Osteoporosis Kidney Disease Hepatitis/Jaundice Sexually Transmitted Disease Stomach Troubles/Ulcers Acid Reflex Joint Replacement/Implant Chest Pains Recent Weight Loss Radiation Therapy Liver Disease Recent Weight Loss Heart Trouble Mitral Valve Prolapse Other Are you taking any medication(s) including non-prescription medicine? Dental History No Dental History No No No No No No No No No N	, , , , , ,		
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Mode No No No No No No No N			
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Do you use controlled substances? Have you ever had any of the following? High blood pressure			☐ Yes ☐ No
Have you ever had any of the following? High blood pressure		?	
Cardiac Pacemaker Rheumatic Fever Heart Murmur Swollen Ankles Angina Cancer Frequently Tired Asthma Diabetes Fainting/Seizures Emphysema Diabetes Fainting/Seizures Leukemia Arthritis Epilepsy/Convulsions Osteoporosis Kidney Disease Hepatitis/Jaundice AIDS/HIV Infection Thyroid Problem Sexually Transmitted Disease Stomach Troubles/Ulcers Acid Reflex Joint Replacement/Implant Chest Pains Easily wounded Hay Fever/Allergies Tuberculosis Stroke Radiation Therapy Liver Disease Glaucoma Recent Weight Loss Heart Trouble Respiratory Problem Mitral Valve Prolapse Other Are you taking any medication(s) including non-prescription medicine? Yes No If yes, please list the medication(s). Pental History Name of Previous Dentist & Location Date of Last Exam What is the reason for your dental visit today? How do you feel about your smile? 1. Do your gums bleed while brushing or flossing? 2. Are your teeth sensitive to hot or cold or pressure or sweets? Yes No 3. Does your mouth feel dry? 4. Do you feel pain in any of your teeth? Yes No 5. Do you have any sores or lumps in or near your mouth? Yes No			
Swollen Ankles	High blood pressure	Heart Disease	Heart Attack
Frequently Tired Asthma Low Blood Pressure Fainting/Seizures Leukemia Arthritis Epilepsy/Convulsions Osteoporosis Hepatitis/Jaundice AIDS/HIV Infection Sexually Transmitted Disease Joint Replacement/Implant Hay Fever/Allergies Radiation Therapy Liver Disease Mitral Valve Prolapse Other Are you taking any medication(s) including non-prescription medicine? If yes, please list the medication(s). Dental History What is the reason for your dental visit today? How do you feel about your smile? 1. Do your gums bleed while brushing or flossing? 2. Are your teeth sensitive to hot or cold or pressure or sweets? 3. Does your mouth feel dry? 4. Do you fave any sores or lumps in or near your mouth? Patheria Arthritis Arthritis Arthritis Kidney Disease Arthritis Kidney Disease Acid Reflex Acid Reflex Besily wounded Stroke Glaucoma Respiratory Problem Mitral Valve Prolapse Other Ves No No No If yes, please list the medication(s) including non-prescription medicine? Yes No No Yes No Yes No Yes No Yes No	Cardiac Pacemaker	Rheumatic Fever	Heart Murmur
Low Blood Pressure	Swollen Ankles	Angina	Cancer
Fainting/Seizures Epilepsy/Convulsions Osteoporosis Hepatitis/Jaundice Sexually Transmitted Disease Joint Replacement/Implant Hay Fever/Allergies Radiation Therapy Recent Weight Loss Are you taking any medication(s). Dental History Name of Previous Dentist & Location Date of Last Exam What is the reason for your dental visit today? How do you feel about your smile? 1. Do your gums bleed while brushing or flossing? 2. Are your teeth sensitive to hot or cold or pressure or sweets? 3. Does your mouth feel dry? 4. AID you be for the proper of the property of the propert	Frequently Tired	Asthma	Anemia
Epilepsy/Convulsions Osteoporosis Kidney Disease Hepatitis/Jaundice AIDS/HIV Infection Thyroid Problem Sexually Transmitted Disease Stomach Troubles/Ulcers Acid Reflex Joint Replacement/Implant Chest Pains Easily wounded Hay Fever/Allergies Tuberculosis Stroke Radiation Therapy Liver Disease Glaucoma Recent Weight Loss Heart Trouble Respiratory Problem Mitral Valve Prolapse Other Are you taking any medication(s) including non-prescription medicine? Yes No If yes, please list the medication(s). Pental History Name of Previous Dentist & Location Date of Last Exam What is the reason for your dental visit today? How do you feel about your smile? 1. Do your gums bleed while brushing or flossing? 2. Are your teeth sensitive to hot or cold or pressure or sweets? 3. Does your mouth feel dry? 4. Do you feel pain in any of your teeth? 5. Do you have any sores or lumps in or near your mouth? Yes No Yes No	Low Blood Pressure	Emphysema	Diabetes
Epilepsy/Convulsions Osteoporosis Kidney Disease Hepatitis/Jaundice AIDS/HIV Infection Thyroid Problem Sexually Transmitted Disease Stomach Troubles/Ulcers Acid Reflex Joint Replacement/Implant Chest Pains Easily wounded Hay Fever/Allergies Tuberculosis Stroke Radiation Therapy Liver Disease Glaucoma Recent Weight Loss Heart Trouble Respiratory Problem Mitral Valve Prolapse Other Are you taking any medication(s) including non-prescription medicine? Yes No If yes, please list the medication(s). **Dental History** Name of Previous Dentist & Location Date of Last Exam What is the reason for your dental visit today? How do you feel about your smile? 1. Do your gums bleed while brushing or flossing? Yes No 2. Are your teeth sensitive to hot or cold or pressure or sweets? Yes No 3. Does your mouth feel dry? 4. Do you feel pain in any of your teeth? Yes No 5. Do you have any sores or lumps in or near your mouth? Yes No	Fainting/Seizures	Leukemia	Arthritis
Hepatitis/Jaundice	9.	Osteoporosis	Kidney Disease
Sexually Transmitted Disease Joint Replacement/Implant Chest Pains Easily wounded Hay Fever/Allergies Radiation Therapy Liver Disease Recent Weight Loss Mitral Valve Prolapse Other Are you taking any medication(s) including non-prescription medicine? Yes No If yes, please list the medication(s). Pental History Name of Previous Dentist & Location Date of Last Exam What is the reason for your dental visit today? How do you feel about your smile? Dental History 1. Do your gums bleed while brushing or flossing? 2. Are your teeth sensitive to hot or cold or pressure or sweets? 3. Does your mouth feel dry? 4. Do you feel pain in any of your teeth? 5. Do you have any sores or lumps in or near your mouth? Acid Reflex Easily wounded Basily wonded Basily wounded Basily wounded Basily wounded Basily wounded Basily wounded Basily wonded Basily vonded Basil			
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Hay Fever/Allergies Radiation Therapy Liver Disease Recent Weight Loss Heart Trouble Other Are you taking any medication(s) including non-prescription medicine? Yes No If yes, please list the medication(s). Dental History Name of Previous Dentist & Location Date of Last Exam What is the reason for your dental visit today? How do you feel about your smile? 1. Do your gums bleed while brushing or flossing? 2. Are your teeth sensitive to hot or cold or pressure or sweets? 3. Does your mouth feel dry? 4. Do you feel pain in any of your teeth? 5. Do you have any sores or lumps in or near your mouth? Yes No			
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Recent Weight Loss Heart Trouble Respiratory Problem Mitral Valve Prolapse Other Are you taking any medication(s) including non-prescription medicine? Yes No If yes, please list the medication(s). Dental History		Liver Disease	Glaucoma
Mitral Valve Prolapse Are you taking any medication(s) including non-prescription medicine? If yes, please list the medication(s). Dental History Name of Previous Dentist & Location Date of Last Exam What is the reason for your dental visit today? How do you feel about your smile? 1. Do your gums bleed while brushing or flossing? 2. Are your teeth sensitive to hot or cold or pressure or sweets? 3. Does your mouth feel dry? 4. Do you feel pain in any of your teeth? 5. Do you have any sores or lumps in or near your mouth? Yes No Yes No Yes No			
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Date of Last Exam What is the reason for your dental visit today? How do you feel about your smile? 1. Do your gums bleed while brushing or flossing? 2. Are your teeth sensitive to hot or cold or pressure or sweets? 3. Does your mouth feel dry? 4. Do you feel pain in any of your teeth? 5. Do you have any sores or lumps in or near your mouth? Yes No	Name of Previous Dentist & Locati	on	
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3. Does your mouth feel dry? 4. Do you feel pain in any of your teeth? 5. Do you have any sores or lumps in or near your mouth? Yes No			
4. Do you feel pain in any of your teeth?5. Do you have any sores or lumps in or near your mouth?YesNo			
5. Do you have any sores or lumps in or near your mouth? Yes No			
		, , , , , , , , , , , , , , , , , , , ,	
- Have you had any periodontal (gum) treatment? Yes No	· · · · · · · · · · · · · · · · · · ·	lontal (gum) treatment?	☐ Yes ☐ No

Patient's name:		
- Have you had any problems with previous dental treatment?	☐ Yes	□ No
- Have you had prolonged bleeding after extraction?	Yes	No
7. Do you have any clicking/popping or discomfort in the jaws?	Yes	No
8. Do you brux or grind your teeth?	Yes	No
9. Do you have ulcers/sores in the mouth?	Yes	No
10. Do you wear dentures/partials?	Yes	No
11. Do you participate in active recreational activities?	Yes	No
12. Have you ever had serious injury to head or mouth?	Yes	No
13. Do you drink bottled/filtered water?	Yes	No
14. Do you grind your teeth?	Yes	No
15. Do you have any neck pains or earaches?	Yes	No
16. Date of last Dental X-Rays	Yes	No
health. I will not hold my dentist or his staff responsible for any action the of errors or omissions that I have made in completion of this form.		
Signature of Patient/Legal Guardian Dat	e	
Signature of Patient/Legal Guardian Date GENERAL DENTISTRY INFORME		SENT
	ecessary by the to; examinate amalgam or call) treatments tetics carries	ne providers at ions, X-rays, composite s, extractions, a small risk for