HEALTH HISTORY

Have you experienced or are you experiencing any of the following?

	Yes	No		Yes	No		Yes	No
Allergies	☐	☐	Liver Disease	☐	☐	Cerebal Palsy	☐	☐
Anemia	☐	☐	Hepatitis Type___	☐	☐	Nervous Problems	☐	☐
Arthritis	☐	☐	Hernia	☐	☐	Tobacco Use	☐	☐
Asthma/Bronchitis	☐	☐	Herpes	☐	☐	Alcohol/Drug Abuse	☐	☐
Emphysema	☐	☐	Kidney Disease	☐	☐	Psychiatric Care	☐	☐
Respiratory Disease	☐	☐	Measles	☐	☐	Heart Disease	☐	☐
Pneumonia	☐	☐	Mumps	☐	☐	Heart Murmur	☐	☐
Tuberculosis	☐	☐	Tonsillitis	☐	☐	Heart Attack	☐	☐
Bleeding Problems	☐	☐	Migraine Headaches	☐	☐	Heart Problems	☐	☐
Blood Transfusion	☐	☐	Prostate Problems	☐	☐	Mitral Valve Prolapse	☐	☐
Tumors/Growths	☐	☐	Osteoporosis	☐	☐	Pacemaker	☐	☐
Cancer	☐	☐	Shortness of Breath	☐	☐	Chest Pain	☐	☐
Chemotherapy	☐	☐	Sinus Trouble	☐	☐	High Blood Pressure	☐	☐
Radiation Therapy	☐	☐	Skin Rash	☐	☐	Low Blood Pressure	☐	☐
Circulatory Problems	☐	☐	Thyroid Problems	☐	☐	Scarlet Fever	☐	☐
Dizziness	☐	☐	Ulcer	☐	☐	Rheumatic Fever	☐	☐
Double Vision	☐	☐	Venereal Disease	☐	☐	Epilepsy/Seizures	☐	☐
Glaucoma	☐	☐	Muscular Dystrophy	☐	☐	Diabetes	☐	☐
Eating Disorder	☐	☐	Multiple Sclerosis	☐	☐	HIV/AIDS	☐	☐
Canker Sores	☐	☐	Stroke	☐	☐	Are you pregnant?	☐	☐

Any other condition? Please Describe_____

Please List Allergies_____

Please List Medications/Vitamins/Herbals

Medication_____ Dose_____ Reason_____

Medication_____ Dose_____ Reason_____

Medication_____ Dose_____ Reason_____

Medication_____ Dose_____ Reason_____

Medication_____ Dose_____ Reason_____

Have you been hospitalized or had surgery in the last 5 years? Please describe_____

_____

_____

Mouth	Yes	No	**Teeth**	Yes	No
Bleeding, sore gums	☐	☐	Loose teeth	☐	☐
Unpleasant taste/bad breath	☐	☐	Sensitive to hot	☐	☐
Burning tongue/lips	☐	☐	Sensitive to cold	☐	☐
Frequent blisters, lips/mouth	☐	☐	Sensitive to sweets	☐	☐
Swelling/lumps in mouth	☐	☐	Sensitive to biting	☐	☐
Ortho treatment (braces)	☐	☐	Food impaction	☐	☐
Biting cheeks/lips	☐	☐	Clenching/grinding	☐	☐
Clicking/popping jaw	☐	☐	Shifting of teeth	☐	☐
Difficulty opening/closing jaw	☐	☐	Change in bite	☐	☐

Please describe any current problems and symptoms_____

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To the best of my knowledge, all of the preceding answers are true and correct. If there is a change in my health or medication, I will inform the dentist at the next appointment.

Signature_____ Date_____