Health History Form

Patient Name: _____ Birthdate _____ Age _____

DENTAL HISTORY

Reason for Visit / Main Concern? Checkup☐ Cleaning☐ Toothache☐ Other_____

1. Have you had gum (periodontal) treatment? _____ **2.** Do your gums bleed easily? _____

3. Have you ever had prolonged bleeding after an extraction? _____ If yes, please specify _____

4. Do you grind your teeth, clench your jaws, or have symptoms near your ears such as clicking, popping, pain, or locking open? _____ If yes, please specify _____

5. Do you feel you have bad breath? _____ **6.** Are your teeth sensitive to hot or cold? _____

7. Would you like your teeth whiter? _____ **15.** Are you happy with your smile? _____ If no, please explain:

_____

MEDICAL HISTORY

1. Are you under a doctor's care at this time? _____ If yes, please specify _____

Dr. Name _____ Phone number (_____) _____

2. Are you allergic to any drugs or medicine? _____

3. List current medications _____

_____

4. (Women) Are you pregnant now? _____ If yes, how many weeks? _____ Are you nursing? _____

5. Do you have, or have you had, any of the following **(please check 'YES' or 'NO')**?

YES/NO	YES/NO	YES/NO
☐ ☐ Acid Reflux	☐ ☐ Alcoholism	☐ ☐ Anemia
☐ ☐ Artificial heart valve	☐ ☐ Asthma	☐ ☐ Angina
☐ ☐ Arthritis	☐ ☐ Bleeding problems	☐ ☐ Bisphosphonate therapy
☐ ☐ Cancer	☐ ☐ Drug addiction	☐ ☐ Chemo / Radiation therapy
☐ ☐ Diabetes	☐ ☐ Dizzy spells	☐ ☐ Epilepsy
☐ ☐ Emphysema	☐ ☐ Fainting	☐ ☐ Glaucoma
☐ ☐ Herpes	☐ ☐ Heart murmur/problems	☐ ☐ Heart attack/surgery
☐ ☐ Hepatitis	☐ ☐ Jaundice	☐ ☐ High Bl. pressure
☐ ☐ Joint replacement	☐ ☐ Lung disease	☐ ☐ Kidney disease
☐ ☐ Liver problems	☐ ☐ Sinus trouble	☐ ☐ Low Bl. pressure
☐ ☐ Pacemaker	☐ ☐ Sleep apnea	☐ ☐ Psychiatric care
☐ ☐ Rheumatic fever	☐ ☐ Tuberculosis	☐ ☐ Tobacco
☐ ☐ Stroke	☐ ☐ TMD or TMJ	☐ ☐ Thyroid problems
☐ ☐ Venereal disease	Other conditions: _____	

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist (Monfredi Family Dental) of any change in my health and/or medication history. I further certify that I consent to taking X-rays and an oral examination.

_____

Signature of Responsible Party or Patient Date