HEALTH HISTORY

This is confidential information and will not be released without your permission. Please fill this out completely ***before your appointment***, so that the time allotted can be utilized for clinical examination and questions.

Patient's Full Legal Name: ____

Birthdate: ____________________ Date: ____________________

(Circle)

1. Yes No Do you have any specific dental problems or concerns at this time?
2. Yes No Do you frequently have sores in your mouth or on your lips?
3. Yes No Have you ever been told you have gum disease?
4. Yes No Have you ever had specialized treatment for gum disease?
5. Yes No Do you have a problem with frequent tooth decay?
6. Yes No Do you have a problem with a dry mouth?
7. Yes No Have you ever had root canal treatment?
8. Yes No When you move your jaw, do you ever experience any pain or noises by your ears?
9. Yes No Do you ever experience any limited motion when opening or moving your mouth?
10. Yes No Have you ever had TMJ (jaw joint) problems or treatment?
11. Yes No Have you ever had removable partial dentures or full dentures?
12. Yes No Do you wish the color of your teeth were whiter?
13. Yes No Do you ever wish your smile could be improved?
14. Yes No Are you dissatisfied with your ability to chew food?
15. Yes No Do you grind or clench your teeth?
16. Yes No Do you participate in physical activities or sports where you could be accidentally struck in the mouth?
17. Yes No Do you now use dental appliances, such as orthodontic retainers, TMJ splints, snoring appliances, night guards, athletic mouthguards, etc.?
18. Yes No Do you have any mouth habits, such as thumb or finger sucking, pencil or fingernail chewing, mouth breathing, cheek biting, etc.?
19. Yes No Does food regularly get stuck between certain teeth?
20. Yes No Do you have teeth that are sensitive to cold, hot, hard, sweets, air, chewing, or toothbrushing?
21. Yes No Have you ever had an upsetting experience at a dental office?
22. Yes No Do you have a significant fear or anxiety of dental treatment?

What bothers you about having dental treatment? ____

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Is there anything that we could do to help reduce your anxiety during dental treatment?

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Physician's Name: ____

Office Phone: _________________________ Date of your last medical exam?: ____________________

Other health care providers that you use, such as chiropractors, herbalists, homeopaths, acupuncturists, nutritionists, physical therapists, etc.:

Name____ Phone ____________________

Name____ Phone ____________________

Name____ Phone ____________________

Name____ Phone ____________________

Name____ Phone ____________________

(over)

What medications or substances are you allergic to, or do not tolerate well? (including **latex** sensitivity)

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(Circle)

1. Yes No Are you now under constitutional homeopathic care by a homeopath?
2. Yes No Are you now using birth control pills?
3. Yes No Are you pregnant or actively trying to become pregnant?
4. Yes No Have you had any heart conditions or treatment (such as heart attack, abnormal blood pressure, heart murmur, heart surgery, rheumatic fever, pacemaker, bacterial endocarditis, coronary heart disease, mitral valve prolapse, heart defects, artificial heart valves, or angina)?
5. Yes No Has any doctor recommended taking antibiotics as a preventive measure prior to dental treatment because of a heart condition or a joint replacement?
6. Yes No Have you had any respiratory conditions (such as emphysema, persistent cough, tuberculosis, asthma, hay fever, sinus trouble, or allergies)?
7. Yes No Have you had any liver conditions (such as hepatitis, jaundice, or cirrhosis)?
8. Yes No Have you had venereal disease?
9. Yes No Have you ever had a blood condition (such as hemophilia, sickle-cell anemia, or leukemia)?
10. Yes No Have you ever had a sleep disorder (such as apnea, narcolepsy, or consistent snoring)?
11. Yes No Have you ever had a nervous system condition (such as epilepsy, hyperactivity, loss of memory, stroke, Bell's Palsy, frequent headaches, Parkinson's disease, chronic nerve pain, shingles, M.S., or A.L.S.)?
12. Yes No Have you ever had any mental/emotional conditions (such as depression, phobias, anxiety attacks, suicidal thoughts, manic-depression, schizophrenia, or obsessive-compulsive behavior)?
13. Yes No Have you ever had any other joint conditions (such as arthritis, rheumatism, artificial joints)?
14. Yes No Have you ever had any lymphatic system disorders (such as lymphoma, Hodgkin's disease, A.I.D.S. or H.I.V. positive status)?
15. Yes No Do you have any organ dysfunction (such as diabetes, thyroid disease, kidney failure, or pancreatitis)?
16. Yes No Have you ever had any digestive system disorders (such as stomach ulcers, Crohn's disease, colitis, or intestinal parasites)?
17. Yes No Do you have any autoimmune system disorders (such as lupus erythematosis, multiple allergies, rheumatoid arthritis, or chronic fatigue)?
18. Yes No Do you have any skin problems (such as acne, itching, rashes, dry skin, warts)?
19. Yes No Have you ever had cancer?
20. Yes No Have you ever had an eating disorder (such as bulimia or anorexia)?
21. Yes No Have you ever been a victim of mental, physical, or sexual abuse?
22. Yes No Do you use recreational drugs?
23. Yes No Have you ever had a substance abuse problem?
24. Yes No Do you smoke cigarettes or cigars?
25. Yes No Do you use chewing tobacco?
26. Yes No Do you drink alcoholic beverages?
27. Yes No Do you drink caffeinated beverages?
28. Yes No Do you drink carbonated soft drinks?
29. Yes No Are you on a special diet?

What illnesses or health issues do you have that are not mentioned above or that you want us to know about?

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