**Health History**

It is important that we know about your medical history. Many things have a direct bearing on your dental health. We will review the questionnaire and discuss it with you in detail. Information you give is strictly confidential and will not be released to anyone without your written permission.

Physician’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Physical Exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nearest Relative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle any of the following which the patient has had or now has:

Heart Disease Asthma Drug Addiction Angina Pectoris

Hay Fever Hemophilia Sinus Trouble High Blood Pressure

Heart Murmur Allergies Ulcers Bruises Easily

Rheumatic Fever Diabetes Anemia Congenital Heart Disease

Thyroid Disease Arthritis Cancer Scarlet Fever

Stroke Liver Disease Artificial Joint Rheumatism

Hepatitis A Hepatitis B Kidney Trouble Jaundice

Aids Glaucoma Excessive Bleeding Sickle Cell

Emphysema Chronic Cough Venereal Disease Cold Sores

Hives Heart Surgery Epilepsy/Seizures Artificial Heart Valves

X-Ray/Cobalt Treatment Pain/noises in joints Pacemaker None of the above

Please explain any conditions circled above\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is there anything else regarding your health, not listed above, that should be documented in your health history? Yes\_\_ No\_\_ Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Does/did the patient ever suck a finger, lip or tongue? Yes\_\_\_\_ No\_\_\_\_

Does the patient grind or clench their teeth at night Yes\_\_\_\_ No\_\_\_\_

Does the patient frequently breathe through their mouth Yes\_\_\_\_ No \_\_\_\_

Has the patient been treated for respiratory problems Yes\_\_\_\_ No\_\_\_\_

Has the patient been hospitalized or under a physicians care in the last 2 years?

Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the patient ever experienced trauma to the head, face, jaw or teeth?

Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medications taken in the past 2 years\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Allergies to Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the patient have any conditions such as:

Mitral Valve Prolapse, Repaired cardiac septal defects or artificial heart valves that require premedication with antibiotics for dental procedures? Yes\_\_\_\_\_ No\_\_\_\_\_

**Women:** Are you pregnant? Yes\_\_ No\_\_ Are you taking Bisphosphonates Yes\_\_ No\_\_

Are you taking medication for Osteopenia or Osteoporosis? Yes\_\_ No\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Patient, Parent or Guardian Date

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Print Name