# CONTEMPORARY DENTISTRY AND IMPLANTOLOGY
# PATIENT HEALTH HISTORY

| **Name:** | **Date of Birth:** |
|---|---|

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

| | **YES** | **NO** | | **YES** | **NO** |
|---|---|---|---|---|---|
| 1. Are you in good health? | | | 12. Have you ever taken Fen-Phen/Redux? | | |
| 2. Have there been any changes in your general health within the past year? | | | 13. Do you use tobacco? | | |
| 3. Date of your last physical exam: | | | 14. Do you or have you used controlled substances? | | |
| 4. Physician's Name<br>Address<br>Phone | | | 15. Are you wearing contact lenses? | | |
| 5. Are you currently being treated for any ongoing medical condition? | | | 16. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? | | |
| 6. Have you ever been hospitalized for any surgical operation or serious illness? Please explain. | | | 17. Do you have any disease, condition or problem not listed above that you think I should know about? | | |
| 7. Are you taking any medicine(s) including non-prescription medicine? If yes, please list below. | | | | | |

| Medication: | Dosage: | Medication: | Dosage: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| | | | **WOMEN ONLY** | **YES** | **NO** |
|---|---|---|---|---|---|
| 8. Have you had any abnormal bleeding? | | | | | |
| 9. Do you bruise easily? | | | 18. Are you pregnant or think you may be pregnant? | | |
| 10. Have you ever required a blood transfusion? | | | 19. Are you nursing? | | |
| 11. Have you had a recent weight loss? | | | 20. Are you taking birth control pills? | | |
| | | | 21. Are you taking any medications for osteoporosis? | | |
| | | | If yes, which one? | | |

**Are you allergic to or have you had any reactions to:**

| | **YES** | **NO** | | **YES** | **NO** |
|---|---|---|---|---|---|
| Local anesthetics like Novocain | | | NSAIDS (Advil, Motrin) | | |
| Penicillin or other antibiotics | | | Any metals (e.g., nickel, mercury, etc.) | | |
| Sulfa drugs | | | Latex or rubber | | |
| Barbiturates, sedatives or sleeping pills | | | Other (please list) | | |
| Aspirin | | | Iodine | | |

# PATIENT HEALTH HISTORY

**Do you have or have you ever had the following:**

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Rheumatic heart disease or rheumatic fever | | | Joint replacement or implant | | |
| Scarlet fever | | | Stomach ulcer | | |
| Heart defect or heart murmur | | | Kidney trouble | | |
| Heart trouble, heart attack, or angina | | | Tuberculosis | | |
| Chest pain | | | Persistent cough | | |
| Shortness of breath | | | Cough that produces blood | | |
| Pacemaker | | | Chemotherapy (cancer, leukemia) | | |
| Heart surgery | | | Sexually transmitted disease | | |
| High/low blood pressure | | | Epilepsy or seizures | | |
| Congenital heart problem | | | Anemia | | |
| Swelling of feet, ankles, hands | | | Glaucoma | | |
| Hepatitis, jaundice or liver disease | | | Nervousness | | |
| Stroke | | | Tonsillitis | | |
| Sinus trouble | | | Tumors | | |
| Lung or breathing problems | | | Mental health care | | |
| Asthma or hay fever | | | Back problems | | |
| Hives or skin rash | | | Chemical dependency | | |
| Fainting or dizzy spells | | | Mitral valve prolapse | | |
| Diabetes | | | Cortisone treatment | | |
| AIDS or HIV infection | | | Cold sores/fever blisters | | |
| Thyroid problems | | | Hypoglycemia | | |
| Allergies | | | Eating disorders | | |
| Arthritis or Rheumatism | | | Cancer | | |

## PATIENT DENTAL HISTORY

| | |
|---|---|
| What is the reason for this visit? | |
| When was your last dental visit? | |
| What was done then? | |
| How often did you visit the dentist before then? | |
| Previous dentist (name and location). | |
| Have you had a complete series of dental films (x-rays) taken? When and where? | |
| How often do you brush your teeth? | |
| How often do you floss your teeth? | |
| Is your drinking water fluoridated? | |

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Do your gums bleed while brushing or flossing? | | | Do you clench or grind your teeth? | | |
| Are your teeth sensitive to hot or cold liquids/foods? | | | Do you bite your lips or cheeks frequently? | | |

# PATIENT HEALTH HISTORY

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Are your teeth sensitive to sweet or sour liquids/foods? | | | Have you noticed any loosening of your teeth? | | |
| Do you feel pain to any of your teeth? | | | Does food tend to become caught between your teeth? | | |
| Do you have any sores or lumps in or near your mouth? | | | Have you ever had periodontal treatment (gums)? | | |
| Have you ever experienced any of the following problems in your jaw? | | | Have you ever worn a bite plate or other appliance? | | |
| Clicking | | | Have you ever had any difficult extractions in the past? | | |
| Pain (joint, ear, side of face) | | | Have you ever had any prolonged bleeding following extractions? | | |
| Difficulty in opening or closing | | | Do you wear dentures or partials? | | |
| Difficulty in chewing | | | If yes, date of placement | | |
| Do you have frequent headaches? | | | Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | | |

If you could change anything about your smile, what would you change?

**AUTHORIZATION AND RELEASE**

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

| Signature of patient or parent/guardian, if minor. | Date: |
|---|---|

Doctor's Comments:

| Signature of doctor: | Date: |
|---|---|