Chart#_____

Health History

Patient Name:_____ Today's Date _____
What is the reason for your visit today?_____
When was your last dental visit?_____
Do you have any dental problems now? Please describe:_____

DENTAL HISTORY

Have you ever had an unfavorable reaction to dental treatment?	Yes	No
Have you ever had an unpleasant dental experience?	Yes	No
Do you have sensitive teeth?	Yes	No
Do your gums bleed?	Yes	No
Do you clench or grind your teeth while awake or asleep?	Yes	No
Have you ever had any injuries to your face or jaw?	Yes	No
Have you ever had a local anesthetic (Novocaine, etc.)?	Yes	No
Have you ever had any unfavorable reaction from local anesthetic?	Yes	No

MEDICAL HISTORY

Are you in good health?	Yes	No
Are you under the care of a physician?	Yes	No
If so, what is the condition you are being treated for? _____		
Have you ever had any serious illness or operation?	Yes	No
If so, what illness or operation?_____		
Are you taking any ☐ medications, ☐drugs, ☐herbs, ☐ over the counter medications?	Yes	No
Ifso,what?_____		
_____		
What dosage?_____		
Are you sensitive or allergic to any drugs or materials?	Yes	No
☐ penicillin, ☐ tetracycline, ☐ sulfa Drugs, ☐ Aspirin, ☐ codeine, ☐latex, ☐ other		
If other, what drug?_____		
Do you smoke? If yes, how much? _____ ☐ Cigarettes ☐ cigars ☐ Packs per day	Yes	No

Do you have or have you had any of the following (Please circle Yes or No- answer all conditions):

Heart Murmur	Yes	No	Anemia	Yes	No	Allergies	Yes	No	Hemophilia	Yes	No
Chest Pain	Yes	No	Artificial Joints	Yes	No	Radiation Therapy	Yes	No	High Blood Pressure	Yes	No
Heart pacemaker	Yes	No	Kidney Trouble	Yes	No	Tumor/Cancer	Yes	No	Epilepsy/Seizures	Yes	No
Ulcers	Yes	No	Diabetes	Yes	No	Hepatitis	Yes	No	Psychological Treatment	Yes	No
Tuberculosis	Yes	No	Thyroid Problems	Yes	No	Cold Sores/Blister	Yes	No	Neurological Disorder	Yes	No
Asthma	Yes	No	Sinus Trouble	Yes	No	Artificial Valve	Yes	No	Mitral Valve Prolapse	Yes	No
HIV Positive	Yes	No	Emphysema	Yes	No	Liver Disease	Yes	No	Arthritis/Rheumatism	Yes	No

Do you have or have you had any disease, condition or problem not listed above?_____
Have you ever taken the drugs ☐ Fen-phen, ☐ Redux or any ☐ diet drugs? Yes No
Women: Are you pregnant?_____ Months?_____ Nursing?_____ Taking birth control pills or hormones?____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you.

Patient/Guardian Signature:_____Date:_____
Doctor Signature:_____Date:_____

UPDATE 1- Since your last visit:

Have you seen a medical doctor?	Yes	No
Have you had a change in your medication?	Yes	No

Please note changes in your health since last visit. _____

_____

Date _____ Signature_____

UPDATE 2- Since your last visit:

Have you seen a medical doctor?	Yes	No
Have you had a change in your medication?	Yes	No

Please note changes in your health since last visit _____

_____

Date_____Signature_____