HEALTH INFORMATION

PATIENT NAME: ____ **DATE:** ____ /____ /______

Date of Last Dental Visit _____/ _____ /________
What concerns brought you to the Dentist today? ______________________________________
____

Do you require antibiotics before dental treatments _____Yes ______No
Are you currently in pain? _____Yes ______No
Have you ever had a serious/difficult problem associated with any previous dental work? _____Yes ______No
Do you have or have you ever experienced pain/discomfort in your jaw joint?(TMJ/TMD)? _____Yes ______No
Your current dental health is: _____Good _____Fair ______ Poor
Do you like your smile? _____Yes _____No
Do your gums bleed? _____Yes _____No
How many times a week do you FLOSS? __________
How many times a day do you BRUSH? __________
What type of bristles do you use on your toothbrush: ______Soft _____ Medium _____ Hard
How often do you replace your toothbrush? ____________________________
Are your teeth sensitive to heat, cold or anything else? __________________________
Have you lost any teeth? ______Yes ______No If yes, explain: ______________________________
____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies
  ____
  ____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
  Pacemaker
- ☐ **Pregnancy**
  Due date:__________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
  - o Tetracycline
  - o Other
  - o Erythromycin
- o Metals/Plastics
- o Dental Anesthetics
- o Latex
- o Aspirin
- o Any other drug/ material allergies? Please List:
  ____
  ____
  ____
  ____

Do you use tobacco?? Yes_____ No_________ if Yes –Smoke_____ or Chew________

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____
- Name of Physician: ________________________________ Phone: ______________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:____
  ____

Please list any Medications you are currently taking__________________________________
____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Sign: ____ Date: ________________