

Comprehensive Health History

Patient Name: _____ Date: _____

**It is important that we know about your Dental and Medical History. These facts may have a direct bearing on your dental health. This information is strictly confidential and will not be released to anyone.
Thank you for taking the time to fill out this questionnaire completely.*

Medical History

Are you currently under the care of a physician? _____ If yes, please explain: _____

Name of physician(s): _____

Are you currently taking any prescription medications, OTC medications, or vitamins? _____ *

If yes, please list the name of ALL medications/vitamins, the reason you are taking them, and the prescribing doctor if applicable. Use the back of this sheet if necessary. If you have a list, please give it to the receptionist for a copy.

| <u>Medication:</u> | <u>Reason:</u> | <u>Prescribing Doctor:</u> |
|--------------------|----------------|----------------------------|
| | | |
| | | |
| | | |
| | | |

Pharmacy: _____ City of Pharmacy: _____

Please check YES or NO for the following:

- | | YES | NO |
|--|--------------------------|--------------------------|
| Are you currently taking prescription blood thinners? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you currently taking Aspirin daily? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you currently taking fish oil daily? | <input type="checkbox"/> | <input type="checkbox"/> |
| Women: Are you <u>pregnant</u> or <u>currently breastfeeding</u> ? (Circle one) | <input type="checkbox"/> | <input type="checkbox"/> |
| Due date _____ | | |
| Have you ever taken Bisphosphonate medication for osteoporosis? (Brand names include Fosamax, Actonel, Atelvia, Didronel, Boniva) | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you allergic to latex? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you allergic to penicillin? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you aware of being allergic to any other medications or substances? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please list: _____ | | |
| Are you currently taking sleep medication? | <input type="checkbox"/> | <input type="checkbox"/> |

Have you EVER had any of the following? Please check all that apply:

- | | | | | |
|---|---|---|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Headaches | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Material Allergies (latex, wool, metal, chemicals) | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Surgical Implant |
| <input type="checkbox"/> Arthritis (Rheumatism) | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Heart Problems (please describe) _____ | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Swelling of Feet and Ankle |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Cough (persistent) | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Artificial Hip | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Artificial Knee | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Herpes | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Ulcer/Colitis |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shingles | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Shortness of Breath | |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Kidney Disease or Malfunction | | |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | | | |
| <input type="checkbox"/> Cancer | | | | |

Dental History

Reason for your visit today? _____

Approximately how long has it been since your last dental visit? _____

Please check YES or NO for the following:

| | YES | NO |
|--|--------------------------|--------------------------|
| Have you ever responded adversely to dental anesthetic? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please explain: _____ | | |
| Has a medical doctor ever told you that you must take antibiotics prior to dental treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear dentures? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you unhappy with your dentures?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Would you like to know more about permanent replacements? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you apprehensive about dental treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any Periodontal (Gum) treatments? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do your gums bleed, or feel tender or irritated?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Are your teeth sensitive to hot, cold, sweets, pressure? (circle all that apply) | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you unhappy with the appearance of your teeth?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you clench or grind your teeth?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever worn braces?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have discolored teeth that bother you?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you regularly brush your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you regularly floss your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |

Please rank the following in order from 1-4 in which they would keep you from having dental treatment:

Fear of pain: _____ Cost of Treatment: _____ Lack of time: _____ Lack of concern: _____

Patient Signature: _____ **Date:** _____