PATIENT HEALTH HISTORY

Name:_____ DOB:___/____/_____ Gender: ☐ M ☐ F Marital Status: _____

Cell#: _____ Home#: _____ Email:_____

Address:_____ City:_____ State:_____ Zip:_____

Physician Name:_____ Phone#:_____

Please check any of the following that apply to you:

☐ AIDS/HIV	☐ Depression	☐ High Cholesterol	☐ Scarlet Fever
☐ Anemia	☐ Diabetes	☐ Immune Problems	☐ Seasonal Allergies
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Kidney Disease	☐ Seizures
☐ Artificial Joints	☐ Emphysema	☐ Liver Disease	☐ Stomach Problems
☐ Asthma	☐ Excessive Bleeding	☐ Low Blood Pressure	☐ Stroke
☐ Blood Disease	☐ Glaucoma	☐ Mitral valve Prolapse	☐ Thyroid Disease
☐ Bruise Easily	☐ Heart Condition/Surgery	☐ Osteoporosis	☐ Tuberculosis
☐ Cancer	☐ Heart Murmur	☐ Pacemaker	☐ Ulcers
☐ Chemotherapy/Radiation	☐ Hepatitis A,B, or C	☐ Respiratory Problems	☐ Other_____
☐ Chest Pain/Angina	☐ High Blood Pressure	☐ Rheumatic Fever	_____

MEDICATIONS

Are you taking any medications? ☐ Y ☐ N

List of medications:_____

_____

_____

_____

_____

WOMEN ONLY :

Are you taking oral contraceptives? ☐ Y ☐ N

If you are using oral contraceptives, it is important for you to know that antibiotics may interfere with your birth control's effectiveness. You will need to use mechanical forms of birth control for one complete cycle after you finish taking your antibiotics. Please consult with your physician for further guidance. **INTIALS**:_____

Are you or have you taken prescription medications for osteoporosis or bone cancer? ☐ Y ☐ N

Are you pregnant or is there a chance you may be? ☐ Y ☐ N Due Date:___/____/_____

Does your physician require you to be pre-medicated with antibiotics prior to dental treatment for any reason? ☐ Y ☐ N

Are you nursing? ☐ Y ☐ N

Have you ever used Botox or Dermal Fillers? ☐ Y ☐ N

Would you be interested in Botox or Dermal Fillers? ☐ Y ☐ N

ALLERGIES

Mark any known allergies:

☐ Sulfa ☐ Latex ☐ Penicillin ☐ Local Anesthetic ☐ Other:_____

SLEEP / TMJ ASSESSMENT

SLEEP	
Is it easy for you to fall asleep?	☐ Y ☐ N
Do you wake often during the night?	☐ Y ☐ N
Do you feel rested upon waking?	☐ Y ☐ N
Have you been told that you snore while sleeping?	☐ Y ☐ N
Has anyone ever seen you stop breathing while sleeping?	☐ Y ☐ N
Do you use or have you ever tried sleeping with a CPAP or APAP?	☐ Y ☐ N
TMJ	
Do you experience pain in your jaw and/or around your ears?	☐ Y ☐ N
Does your jaw make popping or clicking sounds when your jaw moves?	☐ Y ☐ N
Do you wake up with headaches in the morning or do headaches frequently develop in the evening?	☐ Y ☐ N
Do you grind your teeth at night?	☐ Y ☐ N
Are you prone to neck or shoulder pain?	☐ Y ☐ N

I understand that a thorough health history is important to assist the doctors in providing the safest care possible, and have answered all questions truthfully and to the best of my ability.

Patient/Guardian Signature:_____Date: ___/____/_____

Patient Printed Name:_____ Dentist Signature:_____