

Today's Date \_\_\_\_\_

Patient's Name _____	Prefer to be called _____	Date of Birth _____	<b>OFFICIAL USE ONLY</b> <small>Yes No</small> Pre-Med Comments:   BP: Pulse:
Physician's Name and Address _____			
Physician's Phone _____			
Date of your most recent visit to Physician Reason _____			
How would you assess your general Health?      Good      Fair      Poor			

**To ensure your well being while undergoing treatment in our office, please answer the following questions in detail. All information will be considered confidential and for our records only.**

	Yes	No
1. Are you seeing a physician at the present time for the treatment of a recent or ongoing medical condition?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been hospitalized within the last year? If yes, explain:	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you had a serious illness or operation within the last year? If yes, explain:	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had any serious medical trouble associated with any dental experience? If yes, explain:	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever been advised to take antibiotics (like penicillin, etc.,) before a dental appointment? If yes, explain:	<input type="checkbox"/>	<input type="checkbox"/>

**Do you now or have you had any of the following diseases or problems?**

**Cardiovascular Disease** .....

If yes, check any that apply:

- |                                                |                                                    |
|------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> heart disease         | <input type="checkbox"/> hardening of the arteries |
| <input type="checkbox"/> coronary bypass       | <input type="checkbox"/> stroke                    |
| <input type="checkbox"/> angina                | <input type="checkbox"/> heart murmur              |
| <input type="checkbox"/> mitral valve prolapse | <input type="checkbox"/> congestive heart failure  |
| <input type="checkbox"/> high blood pressure   | <input type="checkbox"/> heart attack              |

	Yes	No
Rheumatic fever or rheumatic heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart defects	<input type="checkbox"/>	<input type="checkbox"/>
Prosthetic (artificial) heart valves	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker? If yes, date of placement _____	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Are you short of breath after mild exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Do your ankles swell?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get short of breath when you lie down?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have chest pain upon exertion?	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding or extended clotting time	<input type="checkbox"/>	<input type="checkbox"/>
Frequent or unexpected nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>

Your normal blood pressure

\_\_\_\_\_ / \_\_\_\_\_

# HEALTH HISTORY

	Yes	No
<b>Diabetes?</b> .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, do you require insulin?	<input type="checkbox"/>	<input type="checkbox"/>
Type and Dose _____		
Do you have an artificial joint? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, which joint(s)? _____		
<b>Hepatitis?</b> .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, check type:		
<input type="checkbox"/> Type A <input type="checkbox"/> Other		
<input type="checkbox"/> Type B <input type="checkbox"/> Non-Specific Type		
<input type="checkbox"/> Type C <input type="checkbox"/> Don't know		
Have you ever required a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what was the date of the transfusion? _____		
Are you HIV positive? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any reason to suspect that you have been exposed to the HIV virus .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had Tuberculosis (TB)? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a TB test? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a cough that has lasted more than 3 weeks? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever cough up blood? .....	<input type="checkbox"/>	<input type="checkbox"/>

**CHECK ANY THAT APPLY:**

- |                                                               |                                                       |
|---------------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Allergies                            | <input type="checkbox"/> Glaucoma                     |
| <input type="checkbox"/> Alzheimer's Disease                  | <input type="checkbox"/> Heart Disease                |
| <input type="checkbox"/> Anemia                               | <input type="checkbox"/> Herpes                       |
| <input type="checkbox"/> Angina                               | <input type="checkbox"/> HIV / AIDS                   |
| <input type="checkbox"/> Asthma                               | <input type="checkbox"/> Jaundice or Liver Disease    |
| <input type="checkbox"/> Arthritis                            | <input type="checkbox"/> Joint Replacement            |
| <input type="checkbox"/> Autoimmune Disease                   | <input type="checkbox"/> Kidney Disease               |
| <input type="checkbox"/> Blood Disorder                       | <input type="checkbox"/> Organ Transplant             |
| <input type="checkbox"/> Cancer                               | <input type="checkbox"/> Osteoporosis                 |
| <input type="checkbox"/> Chemo Therapy                        | <input type="checkbox"/> Parkinson's Disease          |
| <input type="checkbox"/> Chronic/ Recurring<br>Sinus Problems | <input type="checkbox"/> Radiation Treatment          |
| <input type="checkbox"/> Cirrhosis                            | <input type="checkbox"/> Respiratory Problems         |
| <input type="checkbox"/> Depression                           | <input type="checkbox"/> Serious/Frequent Headaches   |
| <input type="checkbox"/> Diabetes                             | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Drug or Alcohol Treatment            | <input type="checkbox"/> Skin Problems                |
| <input type="checkbox"/> Eating Disorder                      | <input type="checkbox"/> Tuberculosis                 |
| <input type="checkbox"/> Epilepsy or Other Seizures           | <input type="checkbox"/> Ulcers                       |
|                                                               | <input type="checkbox"/> Other _____                  |

	Yes	No
Do you consider yourself currently under an <u>abnormally</u> high amount of stress?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any <u>unexplained</u> or <u>unplanned</u> weight loss recently?	<input type="checkbox"/>	<input type="checkbox"/>
Do you now or have you ever smoked? (Please circle) Cigarettes   Pipe   Cigar   Other If you currently smoke, how much? _____ If you have smoked in the past but no longer smoke, when did you quit? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you chew tobacco? If yes, how often? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol? If yes, how much? _____	<input type="checkbox"/>	<input type="checkbox"/>

# HEALTH HISTORY

**WOMEN:**

- |                                                   |                          |                          |
|---------------------------------------------------|--------------------------|--------------------------|
| Are you currently pregnant?                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Expected delivery date _____                      |                          |                          |
| Do you take birth control meds?                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you nursing?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you currently on hormone replacement therapy? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had a mamogram?                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Date _____                                        |                          |                          |

**If you are currently taking these medications, check the box on the left. If you have taken any of these medications within the past year, but are not taking them currently, check the box on the right.**

- | Now                      | Past Year                |                                               |
|--------------------------|--------------------------|-----------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Antibiotics                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Antidepressants (Prozac, Zoloft, etc.)        |
| <input type="checkbox"/> | <input type="checkbox"/> | Antihistamines                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Pressure Medicine                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Thinners                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Cortisone (Prednisone, etc.)                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Cholesterol Medication                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Decongestants                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Diuretics (water pills)                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Hormones (birth control pills, estrogen)      |
| <input type="checkbox"/> | <input type="checkbox"/> | Inhalants                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Insulin                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Medicine for Heart Problems                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle Relaxants                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Nitroglycerine                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain Medicine (Aspirin, Advil, Tylenol, etc.) |
| <input type="checkbox"/> | <input type="checkbox"/> | Prescription Pain Medication                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleeping Pills                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Medicine                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Tranquilizers                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Vitamins                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Others _____                                  |

Please list all current medications you take below:

**Are you ALLERGIC to any of the following medications (do you get hives, a rash, have trouble breathing, etc.):**

- Antibiotics (penicillin, tetracycline, etc .)
- Local Dental Anesthetics (novacaine)
- Codeine
- Aspirin
- Barbituates or Sedatives
- Tranquilizers
- Others \_\_\_\_\_

Have you ever had an adverse reaction like nausea, dizziness, or feeling "spacey" with any drug or medication?	<input type="checkbox"/>	<input type="checkbox"/>
----------------------------------------------------------------------------------------------------------------	--------------------------	--------------------------

Do you have any disease, condition or problem not previously listed that you feel we should know about?	<input type="checkbox"/>	<input type="checkbox"/>
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# HEALTH HISTORY

## Dental Questions:

Are you in any discomfort now? **Y N** Where? \_\_\_\_\_ How long? \_\_\_\_\_

When was your last visit to a dentist? \_\_\_\_\_ What was done? \_\_\_\_\_

How often do you visit a dentist? \_\_\_\_\_ Date of last x-rays? \_\_\_\_\_

Have you had teeth extracted? **Y N** Any complications? \_\_\_\_\_

Are your teeth sensitive to Hot **Y N** Cold **Y N** Sweets **Y N** Pressure **Y N**

Have you had braces? **Y N** When? \_\_\_\_\_ Have you had periodontal (gum) treatments? **Y N** When? \_\_\_\_\_

Have you ever worn a "night guard"? **Y N** Do you snore? **Y N**

How often do you brush your teeth? \_\_\_\_\_ Do you use an electric brush? **Y N** Floss? **Y N** How often? \_\_\_\_\_

List any other teeth cleaning aids you use? \_\_\_\_\_

Do your gums ever bleed? **Y N** When? \_\_\_\_\_

Does food wedge between certain teeth? **Y N** Where? \_\_\_\_\_

Does your jaw ever click or pop? **Y N** Where and when? \_\_\_\_\_

Do you get frequent headaches? **Y N** Do you ever wake-up with a headache? **Y N** How often? \_\_\_\_\_

Are you aware of any lump or swelling in your mouth? **Y N** Do you bite your fingernails? **Y N**

Were you satisfied with your previous dentist? **Y N** Explain \_\_\_\_\_

What are your expectations of our office? \_\_\_\_\_

What are your goals for your mouth, teeth and smile? \_\_\_\_\_

Are you unhappy with the appearance of your teeth? \_\_\_\_\_

Would you like your smile to look better or different? \_\_\_\_\_

Would you like your teeth to be whiter? **Y N**

Please circle any of the following which have kept you from having the best dental care possible:

Fear of Pain

Cost of Treatment

Lack of Concern

Missing Work Time

*I certify that I have read and understand the questions above. Any questions that I had in regards to these questions have been answered to my complete satisfaction. I will not hold Dr. St. Clair or any other member of the staff of this office responsible for any errors or omissions that I may have made in completion of this form. I will advise this office and Dr. St. Clair of any changes in my physical, dental or general health condition as well as changes in my medications.*

\_\_\_\_\_  
Signature (parent/guardian)

\_\_\_\_\_  
Date

# HEALTH HISTORY