

## PATIENT HEALTH HISTORY

PATIENT'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

CHIEF ORAL COMPLAINT: \_\_\_\_\_

DATE OF LAST DENTAL EXAM \_\_\_\_\_

### PLEASE CHECK OFF THE ITEMS THAT YOU HAVE OR USE:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Sensitivity to cold, hot, pressure, sweets | <input type="checkbox"/> Bad breath                     | <input type="checkbox"/> Cigarettes, pipe, or cigars |
| <input type="checkbox"/> Bleeding gums, How long                    | <input type="checkbox"/> Unpleasant taste               | <input type="checkbox"/> Fluoride supplements        |
| <input type="checkbox"/> Food impaction                             | <input type="checkbox"/> Unfavorable dental experience  | <input type="checkbox"/> Frequency of brushing _____ |
| <input type="checkbox"/> Clenching or grinding                      | <input type="checkbox"/> Complications from extractions | <input type="checkbox"/> Dental floss                |
| <input type="checkbox"/> Pain around ear                            | <input type="checkbox"/> Dental stimulators             | <input type="checkbox"/> Water jet device            |
| <input type="checkbox"/> Swelling or lumps in mouth                 | <input type="checkbox"/> Mouth breathing                | <input type="checkbox"/> Orthodontic treatment       |
| <input type="checkbox"/> Frequent blisters on lips or mouth         |   | <input type="checkbox"/> Periodontal treatment       |

### MEDICAL HISTORY

Physician's Name: \_\_\_\_\_ Date of Last Physical: \_\_\_\_\_

### CHECK ANY OF THE FOLLOWING THAT YOU HAVE HAD OR SUSPECTED:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Hepatitis or Jaundice  | <input type="checkbox"/> Prolonged bleeding           |
| <input type="checkbox"/> Rheumatic fever         | <input type="checkbox"/> Liver disease          | <input type="checkbox"/> Fainting tendency            |
| <input type="checkbox"/> Heart trouble           | <input type="checkbox"/> Cancer or Tumor        | <input type="checkbox"/> Epilepsy                     |
| <input type="checkbox"/> Heart murmur            | <input type="checkbox"/> Tuberculosis           | <input type="checkbox"/> Thyroid disease              |
| <input type="checkbox"/> High/Low blood pressure | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Glaucoma                     |
| <input type="checkbox"/> Chest pain              | <input type="checkbox"/> Kidney bladder trouble | <input type="checkbox"/> Radiation treatment          |
| <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Mental disorders             |
| <input type="checkbox"/> Shortness of breath     | <input type="checkbox"/> Lung disease           | <input type="checkbox"/> HIV or AIDS                  |
| <input type="checkbox"/> Asthma or hay fever     | <input type="checkbox"/> Venereal disease       | <input type="checkbox"/> Prosthetic joint replacement |
| <input type="checkbox"/> Sinus trouble           | <input type="checkbox"/> Blood disease          | <input type="checkbox"/> Blood transfusion            |

List previous surgeries and anesthesia complications. (Use bottom of page if needed)

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### ARE YOU ALLERGIC TO OR DO YOU SUFFER ANY ILL EFFECTS FROM ANY OF THE FOLLOWING:

- |                                     |   |  |
|-------------------------------------|---|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Codeine          | <input type="checkbox"/> Dental anesthesia |
| <input type="checkbox"/> Aspirin    | <input type="checkbox"/> Household bleach | <input type="checkbox"/> Sedatives         |
| <input type="checkbox"/> Latex      | <input type="checkbox"/> Iodine           | <input type="checkbox"/> Other: _____      |

### CHECK ANY OF THE FOLLOWING THAT YOU ARE TAKING OR HAVE TAKEN:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Cortisone drugs     | <input type="checkbox"/> Anticoagulants        | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Steroids            | <input type="checkbox"/> Blood thinners        | <input type="checkbox"/> Sedatives     |
| <input type="checkbox"/> Oral contraceptives | <input type="checkbox"/> Phen-Fen (diet pills) |  |

ARE YOU TAKING ANY OTHER MEDICATIONS?  YES  NO IF YES, PLEASE EXPLAIN: \_\_\_\_\_

It has been explained to me, and I understand that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, I understand that I need to use some additional form of birth control, for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed.

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_