HEALTH HISTORY FORM

INDIVIDUAL INFORMATION

NAME	IF CHILD, PARENT NAME	GENDER	D.O.B.

RESIDENCE	CITY	STATE	ZIP

PHONE	WORK PHONE	EMAIL	EMPLOYER

WHO REFERRED YOU?	PERSON RESPONSIBLE FOR DENTAL INVESTMENT

EMERGENCY CONTACT	PHONE

FOR INSURANCE PURPOSES

PRIMARY CARRIER	GROUP NUMBER

SECONDARY CARRIER	GROUP NUMBER

PERSON INSURED	SOCIAL SECURITY NUMBER	D.O.B.

When was your last dental visit? _____

Why did you leave your last dentist? _____

What is the reason for your visit today? _____

YES	NO	**ARE YOUR TEETH SENSITIVE TO:**
☐	☐	Sweets
☐	☐	Cold
☐	☐	Heat
☐	☐	Biting Pressure
☐	☐	Does food catch between your teeth?
☐	☐	Have you noticed any gum swelling around your teeth?
☐	☐	Do your gums bleed while brushing?
☐	☐	Do you have an unpleasant taste or odor in your mouth?

PROBLEMS OF THE JAW:

☐	☐	Clicking of the jaw
☐	☐	Pain (joints, ears, side of face)
☐	☐	Difficulty opening or closing
☐	☐	Difficulty chewing
☐	☐	Do you ever avoid any part of your mouth while brushing?
☐	☐	Have you had a reaction to a local anesthetic?
☐	☐	Are you dissatisfied with your teeth and their appearance?
☐	☐	Are you deeply concerned about the finances required to return your teeth to excellent dental health?
☐	☐	Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?
☐	☐	Do you smoke?
☐	☐	Have you ever had any teeth removed? How long have they been missing? _____
☐	☐	Do you feel you will eventually wear artificial dentures?
☐	☐	Have you ever had an upsetting dental experience? If yes, please describe: _____
☐	☐	Do you have any fears?
☐	☐	WOMEN: Are you pregnant/trying to get pregnant?
☐	☐	WOMEN: Nursing?
☐	☐	Do you have any general health problems? If yes, please specify _____

YES	NO	
☐	☐	Are you currently under a physician's care? If yes, please specify _____
☐	☐	Taking any medications? Including regular dosages of aspirin? If yes, please specify _____
☐	☐	Have you had surgery? If yes, please specify _____
☐	☐	Have you taken weight loss pills? Any of the following: Fen-Phen, Pondiment, Redux?
☐	☐	Have you taken bone loss prevention drugs? If yes, please specify _____
☐	☐	Are you sleeping well at night?
☐	☐	Do you snore?
☐	☐	Are you currently using a sleep appliance?
☐	☐	Have you ever been diagnosed with sleep apnea?

TO THE BEST OF YOUR KNOWLEDGE HAVE YOU EVER BEEN AFFLICTED WITH:

☐	☐	Heart Ailment
☐	☐	Diabetes
☐	☐	High Blood Pressure
☐	☐	HIV/AIDS
☐	☐	Hepatitis A, B, C
☐	☐	Osteoporosis
☐	☐	Drug Addiction
☐	☐	Alzheimer's Disease
☐	☐	Frequent Headaches
☐	☐	Prolonged Bleeding
☐	☐	Cancer
☐	☐	Chemotherapy
☐	☐	Tumors
☐	☐	Thyroid Problems
☐	☐	Epilepsy or Seizures
☐	☐	Neurological Disorders
☐	☐	Stroke
☐	☐	Liver Disease
☐	☐	Artificial Joints
☐	☐	Sinus Trouble
☐	☐	Rheumatic Fever
☐	☐	Respiratory Disease
☐	☐	Healing Complications
☐	☐	Allergic reactions to any substance or medication? Latex? Sulfa? Penicillin? _____

NOTES: _____

Date _____ Signature _____