HEALTH HISTORY FORM

Name: _____ Date:_____ Email:_____

Address: _____

Cell Phone: _____ Home Phone: _____Work Phone: _____

Employer: _____ Social Security Number: _____ Birthdate: _____

How do you hear about us? _____

What brought you in today? _____

DENTAL HISTORY:

Are you sensitive to (Circle): Heat Cold Sweets Biting Pressure

Do your gums bleed when brushing/Gum Swelling? _____Do you avoid parts of your mouth while brushing? _____

Do you have an unpleasant taste or odor in your mouth? ____ Does foods catch between your teeth a lot? _____

Are you dissatisfied with your teeth or 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? _____

Ever had any teeth removed? _____ How long have they been missing? _____

Do you have fears/anxiety about dental work? _____

PROBLEMS OF THE JAW:

Pain (joints, ears, side of face)? _____ Clicking or popping of the jaw (TMJ)? _____

Difficulty opening or closing/chewing? _____

Have you ever had a sleep study? _____ Have you ever been diagnosed with sleep apnea? _____

Are you currently using a sleep appliance? _____ Are you sleeping well at night? _____ Do you snore? _____

Do you have frequent headaches? _____ If yes, where? _____

MEDICAL HISTORY:

When was your last dental appointment? _____ Do you smoke? _____

Do you have any general health problems? If so, please explain _____

Have you had any surgeries? (Please list) _____

Are you currently on any medications? (Please list) _____

_____

Are you now, or have you ever been, afflicted with any of the following conditions (circle):

Diabetes Rheumatic fever Epilepsy Hepatitis HIV High blood pressure

Respiratory disease Prolonged bleeding Healing complications

Are you allergic to any drugs? _____

Signature_____ Date: _____