HEALTH HISTORY

Do you have or have you ever had any of the following? (Check the boxes that apply)

☐ Congenital Heart Disease	☐ Heart Problems	☐ Pace Maker	☐ High Blood Pressure
☐ Low Blood Pressure	☐ Heart Attack	☐ Artificial Heart Valves	☐ Heart Surgery
☐ Stroke	☐ Rheumatic Fever/Murmur	☐ Dizziness/Fainting	☐ Thyroid Disease
☐ Cancer	☐ Respiratory Disease	☐ Liver Disease	☐ Vertigo
☐ Cold Sores/Fever blisters	☐ Blood Disorders	☐ HIV Positive	☐ Epilepsy/Seizures
☐ Renal Dysfunction	☐ Tuberculosis	☐ Acid Reflux/GERD	☐ Allergies (pollen or dust)
☐ Asthma	☐ Chemical Dependency	☐ Alcohol Dependency	☐ Sinus Problems
☐ Arthritis	☐ Organ Transplant	☐ Joint Replacement	☐ Back/Neck Problems
☐ Blood Thinners	☐ Glaucoma	☐ Tobacco Products	☐ Human Papilloma Virus
☐ Diabetes	☐ Eating Disorder	☐ Psychiatric Care	☐ Mental Health Issues
☐ Sleep Apnea	☐ Other	☐	☐

Please Explain Checked Conditions: ____

____

____

Physician's Name and date of last visit: ____

Do you have any or have you had any of the following allergies:

☐ Epinephrine	☐ Aspirin	☐ Codeine/narcotics	☐ Sulfa	☐ NSAIDS
☐ Latex	☐ Acrylic	☐ Dental Anesthetics	☐ Metals	☐ Jewelry

Any allergies to antibiotics or other allergies: ____

____

Prescription Medications: ____

____

Over the Counter Medications: ____

Herbal Medications: ____

Have you been hospitalized in the last 2 years? .... ☐ Yes ☐ No

If so, for what? ____

Have you taken Cortisone or Steroid Therapy in the last 6 months? .... ☐ Yes ☐ No

Have you ever been affected by dry mouth? .... ☐ Yes ☐ No

Do you or have you ever taken medication for osteoporosis? .... ☐ Yes ☐ No

Have you ever had a Sleep Study done?.................................... ☐ Yes ☐ No

If so why, and what were the results? ____

____

Women: Do you suspect that you are pregnant? .... ☐ Yes ☐ No

Women: Are you nursing? .... ☐ Yes ☐ No

Women: Are you currently taking birth control? .... ☐ Yes ☐ No

DENTAL HISTORY

Have you ever had Orthodontic treatment (braces)? .... ☐ Yes ☐ No

Have you ever been diagnosed with Gum disease or Periodontal Disease? .... ☐ Yes ☐ No

Have you had dental implants placed?.................................... ☐ Yes ☐ No

Are you interested in whitening your teeth?.................................... ☐ Yes ☐ No

Do you have TMJ problems? .... ☐ Yes ☐ No

How long since your last dental visit? ____

Do you have any current dental complaints?____