Health and Dental History

Patient Name _____ Date of Birth: _____

Physician's Name _____ Phone # _____

Are you taking any medication now, including regular doses of aspirin? Yes No

If yes, please list name and dosage: _____

Are you aware of having an allergic reaction to any medication or substance? Yes No

If yes, please list: _____

Have you been under the care of a medical doctor during the past two years? Yes No

If yes, for what? _____

Have you seen:

- An ear, nose and throat doctor? Yes No Name_____
- A chiropractor? Yes No Name _____
- A neurologist? Yes No Name _____

Have you had braces? Yes No Name _____

Indicate if you have had, or currently have the following

Heart concerns	Yes	No	Headaches	Yes	No
Congenital Heart Disease	Yes	No	Jaw Pain	Yes	No
Heart Murmur	Yes	No	Jaw Popping	Yes	No
High blood pressure	Yes	No	Limited Opening	Yes	No
Mitral Valve Prolapse	Yes	No	Congested Ears	Yes	No
Artificial Heart Valve	Yes	No	Dizziness	Yes	No
Pacemaker	Yes	No	Ringing in Ears	Yes	No
Stroke	Yes	No	Loose Teeth	Yes	No
Asthma	Yes	No	Posture Problems	Yes	No
Liver disease/jaundice	Yes	No	Clenching	Yes	No
Latex Sensitivity	Yes	No	Grinding	Yes	No
Artificial Joints	Yes	No	Facial pain	Yes	No
Kidney disease/trouble	Yes	No	Sensitive Teeth	Yes	No
Radiation/chemotherapy	Yes	No	Neck ache	Yes	No
Epilepsy/seizures	Yes	No	Bell's Palsy	Yes	No
Diabetes	Yes	No	Difficulty swallowing	Yes	No
Hepatitis	Yes	No	Difficulty chewing	Yes	No
AIDS/HIV positive	Yes	No	Trigeminal Neuralgia	Yes	No
Sickle Cell Disease	Yes	No	Tingling arms/fingers	Yes	No
Neurological disorders	Yes	No	Insomnia/		
Psychiatric/psychological	Yes	No	Frequent waking	Yes	No

Have you had any disease, condition or problem not listed? _____

Please list cosmetic procedure you have had _____

Does floss shred when you use it? _____ Does food pack or catch between your teeth? _____

Do you smoke or chew tobacco? _____ Do your gums bleed? _____

Does your breath concern you? _____

Women: Are you pregnant? _____ Nursing? _____ Taking birth control? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify the doctor of any change in my health or medication.

Signature: _____ Date: _____