HEALTH HISTORY DENTAL

Patient Name: ______________________________

Date of Birth: ___/___/______

Current Medications, supplements, etc.:		

Allergies: ☐ Penicillin ☐ Codeine ☐ Latex ☐ Other: ______________________________

Date of last Dental Exam: ______________________________

Date of last Dental Visit: ______________________________

Any chance you are pregnant? ☐ Yes ☐ No Nursing Mother? ☐ Yes ☐ No

Do you use: ☐ Tobacco ☐ Alcohol ☐ Marijuana ☐ Other Drugs

Date of last Medical Exam: ______________________________

Name of Primary Physician: ______________________________

Have you ever had a joint replaced or any heart conditions? ☐ Yes ☐ No

Any history of complications following Dental Treatment? ☐ Yes ☐ No

If YES, explain: ______________________________

Are you currently in pain? ☐ Yes ☐ No

Are you happy with your smile? ☐ Yes ☐ No

List past hospitalizations/surgeries: ______________________________

Please Check Conditions that Apply to You in the Past or Present

☐	Anemia/Bleeding Conditions	☐	Hepatitis / Liver Disease
☐	Arthritis / Bone / Muscle Problems	☐	High Blood Pressure
☐	Artificial Joints / Heart Valve	☐	Kidney / Urinary Problems/ Prostate
☐	Asthma / Breathing Problems	☐	Radiation therapy/Chemotherapy
☐	Cancer	☐	Seizures
☐	Depression / Anxiety	☐	Sexually Transmitted Diseases / HIV
☐	Diabetes	☐	Stroke
☐	Head Injury / Migraines	☐	Thyroid / Parathyroid Problems
☐	Heart Disease	☐	TMJ
☐	Heart Murmur / Rheumatic fever	☐	Tuberculosis / Positive TB Test
☐	Pacemaker or Defibrillator	☐	Treatment for osteoporosis
☐	I have taken a medicine called: Fosamax, Alendronate, Risedronate, Actonel, Reclast, Bisphosophonate		
☐	Other:		

Notes:

Patient Signature: **Date:** Provider Initial: Date: