YourBeautifulSmile.com

Your Beautiful Smile
FAMILY DENTISTRY

Health History

Name: _____ Date: _____

Reason for this visit: _____

Please answer the following:

1. Do you have any illness we should know about? _____
2. Have you ever had radiation therapy? ___ If so, for tumor or cancer treatment? _____
3. Have you ever been told to Pre-Medicate before dental treatment? _____
4. Please list all medications, prescription, over the counter and herbal supplements that you take:_____
   _____
5. Have you ever taken ACTH or other types of cortisone or steroids? _____
6. Previous hospitalizations, serious illnesses, or surgical procedures?
   _____
7. At this moment do you have a toothache or any pain in your head or neck?
   _____
8. What are your dental problems? (Please circle all that apply)
   Pain Broken filling/tooth Bleeding gums Need checkup
   Other - please specify_____
9. Do you smoke or use tobacco? If so how often and how much?
   _____
10. There are several ways to improve your smile! Is there anything that you would like to change about your smile?_____

For women only:

Birth Control Yes No Nursing Yes No

Are you pregnant? Yes No If so how many weeks? _____

Physician Name: _____ Phone Number: _____

Physician Address: _____

Emerg. Contact: _____Relationship: _____ Phone Number: _____

ALLERGIES:

Yes	No		Yes	No	
___	___	Aspirin	___	___	Latex
___	___	Codeine	___	___	Metals
___	___	Dental Anesthetics	___	___	Penicillin
___	___	Erythromycin	___	___	Tetracycline
___	___	Jewelry			

List any other allergies: _____

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CONDITIONS:

Yes	No		Yes	No	
___	___	Allergies	___	___	Glaucoma
___	___	Any Bleeding Problems	___	___	Gout
___	___	Arthritis	___	___	Heart Disease
___	___	Artificial Body Parts	___	___	Heart Murmur/Mitral Valve
___	___	Artificial Heart Valve	___	___	Hemophilia
___	___	Asthma	___	___	Hepatitis A
___	___	Autoimmune Deficiency	___	___	Hepatitis B
___	___	Blood Pressure High/Low	___	___	Hepatitis C
___	___	Blood Transfusion	___	___	Kidney Problems
___	___	Bone Dent Meds/Bisphosphonates	___	___	Liver Disease
___	___	Cancer-Chemotherapy	___	___	Pace Maker
___	___	Colitis	___	___	Psychiatric Problems
___	___	Congenital Heart Defect	___	___	Radiation Therapy
___	___	Diabetes	___	___	Rheumatic Fever
___	___	Difficulty Breathing	___	___	Seizures
___	___	Drug Abuse	___	___	Shingles
___	___	Elevated Cholesterol	___	___	Sinus Problems
___	___	Fainting Spells	___	___	Stroke
___	___	Fever Blisters	___	___	Thyroid Problems
___	___	Frequent Cough	___	___	Tuberculosis or Lung Disease
___	___	Frequent Headaches	___	___	Ulcers
			___	___	Venereal Disease

Do you have any other Conditions/Problems not covered above? _____

Print Patient Name: _____

Patient Signature: _____ Date: _____