Northern Counties
HEALTH CARE

Dental Health History Form

Patient Name: _____ Date of Birth: _____

Physician's Name: _____ Physician's Phone Number: _____

Date of last physical exam: _____

Are you in good health at this time? ..... YES NO

Are you currently receiving medical treatment? ..... YES NO

Please explain: _____

Are you taking any prescriptions, over the counter medications or herbal supplements? ..... YES NO

If yes, please list them: _____

Are you allergic to any medications (e.g. codeine, penicillin, sulfa, etc.)? ..... YES NO

If yes, please list them: _____

Are you allergic to any metals in jewelry (nickel or others) or to Latex? ..... YES NO

If yes, please list them: _____

Are you allergic to any foods (bananas, avocados, nuts, kiwi, tomatoes, potatoes, etc)? ..... YES NO

If yes, please list them: _____

Do you use tobacco products of any kind? ..... YES NO

If yes, what type? How often? _____

Women:

Are you pregnant? ..... YES NO

Are you nursing? ..... YES NO

Are you using hormonal birth control? ..... YES NO

PLEASE CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR CURRENTLY HAVE:

Angina	Cancer	Easy Bruising
Heart Problems/Surgeries	Radiation or Chemotherapy	Ulcers
High Blood Pressure	Epilepsy/Seizures	Mental Health Problems
Artificial Heart Valve	Kidney or Liver Problems	Cold Sores
Stroke	Joint Replacements	Hepatitis (please specify type)
Diabetes	Asthma/Respiratory Problems	Anemia
Arthritis/Rheumatoid or other	Drug or Alcohol Addiction	Glaucoma
Tuberculosis	Bleeding Problems	Sinus Problems
AIDS/HIV Positive	Sexually Transmitted Disease	Circulatory Problems
Thyroid Problems	History of Endocarditis	Compromised Immune System

Biophosphate Therapy/ Treatment for Osteoporosis

Please describe any past or current medical condition that may possibly affect your dental treatment:

_____

_____

Dental Health History Form

Please Print Neatly

NEW PATIENTS ONLY

1. How long has it been since your last dental visit? _____
2. What was this for? _____
3. Are you having any problems now? _____
4. Reason for this visit? _____
5. Date of last dental x-rays? _____

NEW AND EXISTING PATIENTS

6. Have you had local anesthetics (Novocaine) for dental work? ..... YES NO
7. Any problems with this? ..... YES NO
8. Do you have dentures? If yes, please circle Upper/Lower ..... YES NO
9. Do they fit well? ..... YES NO
10. Do you have any growths or sore spots in your mouth? ..... YES NO
11. Do your gums bleed? ..... YES NO
12. Do you have any pain in your jaw joints or near your ears? ..... YES NO
13. Do you clench or grind your teeth? ..... YES NO
14. Is any part of your mouth sensitive to cold, hot, sweets, or pressure? ..... YES NO
    If yes, where? _____
15. Does it hurt to chew on any part of your mouth? ..... YES NO
    If yes, where? _____
16. Would you like to learn more about proper care of your mouth and preventative dental care? ..... YES NO
17. Are you nervous about receiving care? ..... YES NO
18. Please state any concerns you have about your dental care:

    _____

    _____

    _____

I hereby certify that I have answered all questions on this form truthfully and, to the best of my knowledge, have not omitted anything. I also certify that I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature:_____ Date:_____

OFFICE USE ONLY:

Medical History Update:

Date:	**Comments:**	**Signature:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____