

HEALTH & DENTAL HISTORY

Name Date

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

If yes, reason

Name of M.D. Phone

List of medications you take including aspirin and nutritional supplements:

Have you had an adverse reaction to any medications? ☐ Yes ☐ No If yes, list and describe below:

Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches/Migraines <input type="checkbox"/> Yes <input type="checkbox"/> No
List <input type="text"/>	Difficulty Swallowing <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease/Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No	Snoring/Sleep Apnea <input type="checkbox"/> Yes <input type="checkbox"/> No
Describe <input type="text"/>	Neck pain <input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Posture Problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you see a chiropractor <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma/Breathing Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	Tingling Arms/Fingers <input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema/Lung Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Facial Pain <input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis/Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain <input type="checkbox"/> Yes <input type="checkbox"/> No
Joint Replacement, If yes, when? <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Popping/Jaw Joint Noise <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="text"/>	Limited Jaw Opening <input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Loose Teeth <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer, If yes, describe below: <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Clenching/Teeth Grinding <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="text"/>	Sensitive Teeth <input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy/Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty Chewing <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Bite Problem <input type="checkbox"/> Yes <input type="checkbox"/> No
H.I.V. <input type="checkbox"/> Yes <input type="checkbox"/> No	Trigeminal Neuralgia <input type="checkbox"/> Yes <input type="checkbox"/> No
Neurological Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had orthodontics? <input type="checkbox"/> Yes <input type="checkbox"/> No
Psychiatric/Psychological issue <input type="checkbox"/> Yes <input type="checkbox"/> No	Crowded tongue <input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting/Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your food pack between teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	Do your gums bleed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma/Eye Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your breath concern you? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you taken Bisphosphonates <input type="checkbox"/> Yes <input type="checkbox"/> No	Other problems not listed here? <input type="checkbox"/> Yes <input type="checkbox"/> No
such as Fosamax, Boniva or other? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, describe <input type="text"/>
Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No	
How many alcohol drinks per week? <input type="text"/>	
Do you use recreational drugs <input type="checkbox"/> Yes <input type="checkbox"/> No	WOMEN ONLY:
Insomnia/Frequent Waking <input type="checkbox"/> Yes <input type="checkbox"/> No	Any chance you might be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
Ear Congestion <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you planning a pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Ringing Ears/Tinitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you nursing <input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you taking birth control pills? <input type="checkbox"/> Yes <input type="checkbox"/> No

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

PATIENT SIGNATURE (signing your name on the line serves as your signature.) **DATE**