Maryanne B. Butler, DDS, MS
Amy M. Riffel, DDS, MS

# Health History

***Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.***

**Name**_____ **Birth date**_____ **Age**_____
Why are you seeking dental treatment?_____
Have you or any member of your family been seen by us before? ( )**Yes** ( )No
If **yes**, which family member(s)? _____
Are you now under the care of a physician? ( )**Yes** ( )No
If so, what is the condition being treated?_____
Date of last ***physical*** examination_____ Physician's Name_____
Date of last ***dental*** examination _____ Date of last dental x-rays_____
Current Dentist's name_____ City/State_____

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- Are you having pain or discomfort at this time? ( )**Yes** ( )No
- Do you feel nervous about having dental treatment? ( )**Yes** ( )No
- Have you ever had a bad experience in a dental office? ( )**Yes** ( )No
- Have you ever been hospitalized or had a serious illness? ( )**Yes** ( )No
  If **yes**, explain _____

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- Are you **ALLERGIC** or have you ever experienced any reaction to the following?

| | | | | | |
|---|---|---|---|---|---|
| Local anesthetics (Novocaine) | ( )**Yes** | ( )No | Aspirin or codeine | ( )**Yes** | ( )No |
| Barbiturates/sedatives/sleeping pills | ( )**Yes** | ( )No | Sulfa drugs | ( )**Yes** | ( )No |
| Penicillin/other antibiotics | ( )**Yes** | ( )No | Latex | ( )**Yes** | ( )No |
| Any type of metal | ( )**Yes** | ( )No | Other allergies_____ | | |

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- Are you **currently taking** any of the following?

| | | | | | |
|---|---|---|---|---|---|
| Antibiotics/sulfa drugs | ( )**Yes** | ( )No | Tranquilizers | ( )**Yes** | ( )No |
| Blood thinners | ( )**Yes** | ( )No | Thyroid medicine | ( )**Yes** | ( )No |
| Insulin/other diabetes drugs | ( )**Yes** | ( )No | Cortisone/steroids | ( )**Yes** | ( )No |
| Blood pressure medicine | ( )**Yes** | ( )No | Recreational drugs | ( )**Yes** | ( )No |
| Antihistamines/allergy drugs | ( )**Yes** | ( )No | OTC cold medications | ( )**Yes** | ( )No |
| Heart medications (digitalis) | ( )**Yes** | ( )No | Nitroglycerin | ( )**Yes** | ( )No |
| Aspirin | ( )**Yes** | ( )No | Vitamins/herbal supplements/ | | |
| Bisphosphonate (fosamax) | ( )**Yes** | ( )No | "cures" | ( )**Yes** | ( )No |

Other medications not listed above you are taking: _____

If **YES** to any of the above, list ***NAME*** of medication and DOSAGE

_____
_____
_____

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- Have you ever been told of any need to pre-medicate with antibiotics for dental procedures? ( )**Yes** ( )No
- Do you currently use tobacco products? ( )**Yes** ( )No
- Have you used tobacco products in the past? ( )**Yes** ( )No
  _____Cigarettes _____Cigars _____Smokeless Tobacco
  Quantity used per day: _____Years of use: _____
- Do you use alcoholic beverages (more than 2 drinks per day)? ( )**Yes** ( )No

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- Do you ***have*** or ***have you ever had*** any of the following?

| | *YES* | *NO* | | *YES* | *NO* | | *YES* | *NO* |
|---|---|---|---|---|---|---|---|---|
| Chest Pain | ____ | ____ | Shortness of Breath | ____ | ____ | Hives or skin rash | ____ | ____ |
| Mitral Valve Prolapse | ____ | ____ | Ulcers | ____ | ____ | Prolonged bleeding | ____ | ____ |
| Heart Disease/Attack | ____ | ____ | Diabetes | ____ | ____ | Cold Sores | ____ | ____ |
| Heart pacemaker | ____ | ____ | Emphysema | ____ | ____ | Glaucoma | ____ | ____ |
| Heart Problems | ____ | ____ | Fainting /dizzy spells | ____ | ____ | Steroid Treatment | ____ | ____ |
| Heart Surgery | ____ | ____ | Eating Disorder | ____ | ____ | Arthritis | ____ | ____ |
| High Blood Pressure | ____ | ____ | Epilepsy or seizures | ____ | ____ | Any type of implant | ____ | ____ |
| Heart Murmur | ____ | ____ | Chronic Cough | ____ | ____ | Sinus trouble | ____ | ____ |
| Rheumatic Fever | ____ | ____ | Tuberculosis (TB) | ____ | ____ | Birth defects | ____ | ____ |
| Congenital heart disease | ____ | ____ | HIV +/ARC/AIDS | ____ | ____ | Liver Disease | ____ | ____ |
| Hepatitis A | ____ | ____ | Hepatitis B | ____ | ____ | Hepatitis C | ____ | ____ |
| Bruise easily | ____ | ____ | Jaundice | ____ | ____ | Artificial joints | ____ | ____ |
| Thyroid Disease | ____ | ____ | Anemia | ____ | ____ | Sickle Cell Disease | ____ | ____ |
| Stroke | ____ | ____ | Kidney Trouble | ____ | ____ | Hemophilia | ____ | ____ |
| Blood transfusion | ____ | ____ | Any type of transplant | ____ | ____ | Mental Health Care | ____ | ____ |
| Asthma | ____ | ____ | Venereal Disease | ____ | ____ | | | |

- Have you ever had or do you currently have cancer? ( )**Yes** ( )No
  If **Yes**, what type_____; chemotherapy and/or radiation? ( )**Yes** ( )No
- **Women**: Are you pregnant? ( )**Yes** ( )No Are you breastfeeding ( )**Yes** ( )No
  Are you taking birth control pills ( ) Yes ( ) No
- Do you have difficulty breathing while lying down? ( )**Yes** ( )No

- Do you ***have*** or ***have you ever experienced*** any of the following problems:

| MOUTH | *YES* | *NO* | TEETH | *YES* | *NO* |
|---|---|---|---|---|---|
| Bleeding/sore gums | ____ | ____ | Loose teeth | ____ | ____ |
| Pain in or around your ears | ____ | ____ | Sensitive to hot | ____ | ____ |
| Difficulty chewing | ____ | ____ | Sensitive to cold | ____ | ____ |
| Difficulty opening or closing jaw | ____ | ____ | Sensitive to sweets | ____ | ____ |
| Unpleasant taste/bad breath | ____ | ____ | Sensitive to biting | ____ | ____ |
| Frequent blisters on mouth/lips | ____ | ____ | Food impaction | ____ | ____ |
| Burning tongue/lips | ____ | ____ | Clenching/grinding | ____ | ____ |
| Swelling/lumps in mouth | ____ | ____ | Shifting of teeth | ____ | ____ |
| Orthodontic treatment (braces) | ____ | ____ | Change in bite | ____ | ____ |
| Biting cheeks/lips | ____ | ____ | Dentures or Partials | ____ | ____ |
| Clicking/popping jaw | ____ | ____ | | | |

- Have you ever had oral surgery, periodontal surgery or treatment? ( )**Yes** ( )No
  If **Yes**, explain/when:_____
- Is there anything you dislike about your smile?_____
- Do you use the following?
  Brush ( )**Yes** ( )No How often do you brush:_____
  Dental Floss ( )**Yes** ( )No How often do you floss:_____
  Fluoride rinse ( )**Yes** ( )No Is your brush: ____ Soft ____ Medium ____ Hard ____ Electric
  Other_____

**I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.**

X_____

**Signature of patient or guardian**