Health History Main

Please fill in the following information. Your answers are for our records only and will be kept strictly confidential subject to applicable laws. Please note that you will be asked some questions concerning your health. This information is vital to allow us to provide you the best care.

General Information

First Name - Patient *

Middle Name

Last Name - Patient *

Nickname/Preferred Name

Dental Information

Please select the box if "yes"

- [ ] Are you currently experiencing dental pain or discomfort?
- [ ] Are your teeth sensitive to cold, hot, sweets, or pressure?
- [ ] Do your gums bleed when you brush or floss?
- [ ] Have you had any problems associated with previous dental treatment?
- [ ] Have you ever had a serious injury to your head, neck, or mouth?
- [ ] Have you had any periodontal (gum) treatment?
- [ ] Have you ever had orthodontic (braces) treatment?
- [ ] Do you grind your teeth?
- [ ] Do you have any clicking, popping, or discomfort in your jaw?
- [ ] Do you wear complete dentures?
- [ ] Do you wear partial dentures?
- [ ] Are you interested in whiter teeth?
- [ ] Are you interested in straighter teeth?
- [ ] Are you happy with your smile?

Sleep Questions

Please select the box if "yes"

- [ ] Do you snore?
- [ ] Do you awake feeling refreshed and well-rested
- [ ] Do you experience morning headaches?
- [ ] Do you clench or grind your teeth?
- [ ] Do you have jaw pain?
- [ ] Do you have neck pain / tightness / stiffness?
- [ ] Do you feel fatigue or overly tired during the day?
- [ ] Have you been told you stop breathing at night?
- [ ] Do you use a CPAP?
- [ ] Have you been diagnosed with Obstructive Sleep Apnea?

Medical Information

Please indicate if you have any of the following allergies.

Allergies

- [ ] Acetaminophen/Tylenol®
- [ ] Acrylic
- [ ] Amoxicillin
- [ ] Animals
- [ ] Aspirin
- [ ] Codeine
- [ ] Dairy
- [ ] Demerol
- [ ] Erythromycin
- [ ] Fluoride
- [ ] Food
- [ ] Hay fever/seasonal
- [ ] Ibuprofen/Motrin®/Advil®
- [ ] Iodine
- [ ] Latex
- [ ] Local anesthetic
- [ ] Metals
- [ ] Morphine
- [ ] Peanuts
- [ ] Penicillin
- [ ] Sulfa
- [ ] Tetracycline
- [ ] Other

Please elaborate on any reactions you have to the indicated allergies

Please indicate if you have any of the following diseases or conditions.

Conditions

- [ ] Abnormal/excessive bleeding
- [ ] AIDS or HIV infection
- [ ] Alzheimer's/dementia
- [ ] Anemia
- [ ] Angina
- [ ] Anxiety
- [ ] Arteriosclerosis
- [ ] Arthritis
- [ ] Artificial Heart Valve
- [ ] Artificial Joint
- [ ] Asthma
- [ ] Autisum
- [ ] Autoimmune disease
- [ ] Back problems
- [ ] Blood disease
- [ ] Blood Thinners
- [ ] Blood transfusion
- [ ] Breathing Problem
- [ ] Breathing problems/respiratory disease
- [ ] Bronchitis
- [ ] Bruise Easily
- [ ] Cancer/chemotherapy/radiation treatment
- [ ] Cardiovascular disease
- [ ] Chemical Dependency
- [ ] Chest pain upon exertion
- [ ] Chronic pain
- [ ] Congestive heart failure
- [ ] CPAP
- [ ] Damaged heart valves
- [ ] Diabetes
- [ ] Drug Addiction
- [ ] Easily Winded
- [ ] Eating disorder
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Excessive Thirst
- [ ] Fainting Spells or Dizziness
- [ ] Fainting spells or seizures
- [ ] Frequent Cough
- [ ] Frequent headaches
- [ ] Gastrointestinal disease
- [ ] G.E. Reflux/persistent heartburn
- [ ] Glaucoma
- [ ] Gout
- [ ] Hard of hearing
- [ ] Hearing difficulties
- [ ] Hearing Impairment
- [ ] Heart attack
- [ ] Heart Attack/Failure
- [ ] Heart murmur
- [ ] Heart rhythm disorder
- [ ] Hemophilia
- [ ] Hepatitis, jaundice or liver disease
- [ ] High blood pressure
- [ ] High Cholesterol
- [ ] Hives or Rash
- [ ] Hypoglycemia
- [ ] Irregular Heartbeat
- [ ] Kidney Disease
- [ ] Kidney problems
- [ ] Latex Sensitivity
- [ ] Leukemia
- [ ] Low blood pressure
- [ ] Low pain tolerance
- [ ] Malnutrition
- [ ] Mitral valve prolapse
- [ ] Multiple Sclerosis
- [ ] Neurological disorders
- [ ] Night sweats
- [ ] Osteoporosis/Paget's disease
- [ ] Other congenital heart defects
- [ ] Pacemaker
- [ ] Pain in Jaw Joints
- [ ] Parathyroid Disease
- [ ] Parkinsons disease
- [ ] Persistent swollen glands in neck
- [ ] Psychiatric care
- [ ] Recent Weight Loss
- [ ] Recurrent Infections
- [ ] Renal Dialysis
- [ ] Rheumatic fever
- [ ] Rheumatic heart disease
- [ ] Rheumatoid arthritis
- [ ] Seasonal Allergies
- [ ] Severe headaches/migraines
- [ ] Severe or rapid weight loss
- [ ] Sexually transmitted infection (STI)
- [ ] Shellfish allergy
- [ ] Shingles
- [ ] Sickle Cell Disease
- [ ] Sinus trouble
- [ ] Spina Bifida
- [ ] Stent
- [ ] Stroke
- [ ] Systemic lupus erythematosus
- [ ] Thyroid problems
- [ ] TMJ Disorder
- [ ] Tuberculosis
- [ ] Tumors or growths
- [ ] Ulcers
- [ ] Other

Do you have any disease, condition or problem that is not listed that you think I should know about?

Please indicate if you use any of the following medications. If your medication is not listed, please enter it in the "Other" text box.

Medications

- [ ] Adderall
- [ ] Allopurinol
- [ ] Alprazolam (Xanax)
- [ ] Amlodipine (Norvasc)
- [ ] Amoxicillin
- [ ] Aspirin
- [ ] Atorvastatin (Lipitor)
- [ ] Azithromycin (Zithromax)
- [ ] Baby Aspirin
- [ ] Birth Control
- [ ] Bupropion (Wellbutrin)
- [ ] Calcium
- [ ] Cephalexin (Keflex)
- [ ] Clopidogrel (Plavix)
- [ ] Eliquis
- [ ] Escitalopram (Lexapro)
- [ ] Famotidine (Pepcid, Zantac)
- [ ] Gabapentin
- [ ] Hydrochlorothiazide
- [ ] Ibuprofen
- [ ] Levothyroxine
- [ ] Lisinopril (Zestril)
- [ ] Metformin (Glucophage)
- [ ] Metoprolol
- [ ] Multivitamin
- [ ] Omeprazole (Prilosec)
- [ ] Penicillin
- [ ] Prednisone
- [ ] Prozac
- [ ] Rosuvastatin (Crestor)
- [ ] Semaglutide-GLP-1 (Ozempic,Terzepatide,Wegovy)
- [ ] Sertraline (Zoloft)
- [ ] Simvastatin
- [ ] Trazodone
- [ ] Vitamins/Minerals
- [ ] Warfarin
- [ ] Zyrtec
- [ ] Other

Pharmacy Information

Preferred Pharmacy

- [ ] Has there been any change to your general health within the past year?
- [ ] Are you pregnant?
- [ ] Are you taking birth control or hormone replacement?
- [ ] Are you nursing?
- [ ] Have you had a serious illness, operation, or been hospitalized in the past 5 years?
- [ ] Do you have severe issues with coughing?
- [ ] Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?
- [ ] Do you currently use cannabis?
- [ ] Do you use tobacco (smoking, snuff, chew, bidis, vaping)?

Please read the above, and understand that the information provided in this form is accurate. A truthful health history will help ensure the best possible dental treatment. The information provided here will be used by the doctor and patient to inform any further discussion of the patient's health prior to or during an appointment. By signing below, you also acknowledge that you will not hold the dentist, the dental practice, or any other member of the practice staff responsible for any action or lack of action because of errors or missed omissions that may have been made during the completion of this form.

Print name

I agree that the information provided in this form is correct to the best of my knowledge.

Signature *

Clear