

Health History

Name: _____ DOB: _____ Age: _____

Gender: _____ Pronouns: _____

Physician's Name: _____ Preferred Pharmacy: _____

Allergies / Allergic Reactions (Check all that apply)

Aspirin Penicillin Erythromycin Codeine Local anesthetic Fluoride Metals Latex

Any other medications: _____

Medical Conditions (Check all that apply)

- ADHD / ADD
- AIDS or HIV positive
- Alcohol / drug dependency
- Anemia or other blood disorder
- Anxiety
- Arthritis
- Asthma
- Autism
- Cataracts / Glaucoma
- Cigarette smoker / smokeless tobacco
- Chronic obstructive pulmonary disease (COPD)
- Emphysema
- Cannabis use
- Depression
- Diabetes
- Epilepsy / convulsions (seizures)
- Frequent headaches
- Head or neck injuries
- Heart problems:
 - Stroke date _____
 - Heart attack date _____
 - Angina
 - Heart murmur
 - Mitral valve prolapse (MVP)
 - Pacemaker
 - A-fib (atrial fibrillation)
 - History of infective endocarditis
- High blood pressure
- High cholesterol
- Hives, skin rash, hay fever
- Thyroid/parathyroid disease

- Cold sores
- Jaundice
- Kidney disease
- Liver disease
- Tuberculosis
- Lupus / autoimmune disease
- Oral lumps or swelling
- Osteoporosis / osteopenia medication
- Cancer / tumor / abnormal growth: Type: _____ Date of diagnosis: _____
- Treatment: Chemotherapy Radiation Surgery Current cancer status: _____

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- Sinus problems
 - Stomach or duodenal ulcer
 - Vision problems / contact lenses
 - Weakness / fatigue

For Women

- Currently pregnant? Yes No
- Trimester: _____
- Nursing? Yes No

Current Medications and Supplements

SLEEP HEALTH (circle your answers)

1. Do you snore?..... Yes No
2. How many times do you wake a night?..... 1 2 3 4+
3. Do you wake feeling rested?..... Yes No
4. If driving longer than 30 minutes do you struggle to stay awake?..... Yes No
5. Have you had your tonsils removed?..... Yes No
6. Once asleep do you struggle staying asleep?..... Yes No
7. Do you struggle to fall asleep?..... Yes No
8. Do you have restless leg syndrome?..... Yes No
9. Do you wake up with a racing heart?..... Yes No
10. Do you wear a nightguard?..... Yes No
11. Do you wear a snore guard?..... Yes No
12. Do you wear a CPAP?..... Yes No

Patient/Guardian Signature: _____) _____ **Date:**

DENTAL HISTORY

Previous dentist: _____ City: _____

How long were you with that dentist? _____ Date of last dental visit:

How often do you normally have your teeth cleaned? (Check one)

- 3 mo. 4 mo. 6 mo. 1 yr Longer

Reason for today's visit:

Have you experienced any of the following?

- Unfavorable dental experience
- Dental fears/anxiety
- Preference for no dental anesthetic
- Tooth pain or sensitivity
- Bleeding gums
- Bad breath
- Loose teeth
- Jaw pain or clicking
- Grinding or clenching teeth
- Dry mouth
- Sores or lumps in mouth
- Neck muscle issues
- Difficulty opening mouth widely

Denture History (Complete if applicable)

The denture(s) I wear is (are) a:

- Complete upper
- Complete lower
- Partial upper
- Partial lower

When did you receive your first denture?

How long have you worn your present denture _____

Has it been relined? When?

Problem with denture?

Satisfied with appearance?

Comfort?

—
Chewing ability?

Patient/Guardian Signature: _____ **Date:** _____