fremont dental

HEALTH HISTORY FORM

As required by law, our office adheres to written policies and procedures to protect the privacy of our patients.

To help us meet your entire dental care needs, please fill out this form completely. Thank You.

***Do you have a primary care physician? What is their name? Where do they practice?** _____*

***Have you ever been hospitalized or had a major operation? If YES:** _____*

***Have you ever had a serious head or neck injury? If YES:** _____*

***Are you taking any medications, pills, or drugs? If YES please list the name of the drug and the condition you are taking it for:** _____*

_____

***How often do you brush and floss your teeth? Brush:** _____ **Floss:** _____ *** Do your gums bleed when you floss or brush your teeth?** ☐ Y ☐ N*

***What type of toothbrush do you use?** ☐ Manual ☐ Electric* ***Do you use tobacco, vapor pens or E cigarettes?** ☐ Y ☐ N*

Women: Are you…. ☐ *Nursing?* ☐ *Taking oral contraceptives or birth control?* ☐ *Pregnant/ Trying to get pregnant?*

Are you allergic to any of the following?

☐ *Aspirin* ☐ *Metal* ☐ *Acetaminophen* ☐ *Penicillin* ☐ *Latex* ☐ *Ibuprofen* ☐ *Codeine* ☐ *Sulfa Drugs*
☐ *Demerol or other Narcotics* ☐ *Acrylic* ☐ *Local Anesthetics* ☐ *Other Allergies?* _____

***Are you required to take antibiotic pre-medication prior to appointments?** ☐ Y ☐ N*

Do you have or have you had any of the following?

☐ *AIDS/ HIV +*	☐ *Cancer*	☐ *Epilepsy or Seizures*	☐ *Heart Murmur*	☐ *Irregular Heartbeat*	☐ *Psychiatric Care*	☐ *Stomach/ Intestinal Disease*
☐ *Alzheimer's Disease*	☐ *Chemotherapy*	☐ *Excessive Bleeding*	☐ *Heart Pacemaker*	☐ *Kidney Problems*	☐ *Radiation Treatments*	☐ *Stroke*
☐ *Anaphylaxis*	☐ *Chest Pains*	☐ *Excessive Thirst*	☐ *Heart Trouble/ Disease*	☐ *Leukemia*	☐ *Recent Weight Loss*	☐ *Swelling of Limbs*
☐ *Anemia*	☐ *Cold Sores/ Fever Blisters*	☐ *Fainting Spells/Dizziness*	☐ *Hemophilia*	☐ *Liver Disease*	☐ *Renal Dialysis*	☐ *Thyroid Disease*
☐ *Angina*	☐ *Congenital heart Disorder*	☐ *Frequent Cough*	☐ *Hepatitis A*	☐ *Low Blood Pressure*	☐ *Rheumatic Fever*	☐ *Tonsillitis*
☐ *Arthritis/Gout*	☐ *Convulsions*	☐ *Frequent Headaches*	☐ *Hepatitis B or C*	☐ *Lung Disease*	☐ *Rheumatism*	☐ *Tuberculosis*
☐ *Artificial Heart Valve*	☐ *Yellow Jaundice*	☐ *Glaucoma*	☐ *Herpes*	☐ *Mitral Valve Prolapse*	☐ *Scarlet Fever*	☐ *Tumors or Growths*
☐ *Artificial Joint*	☐ *Cortisone Medicine*	☐ *Hay Fever*	☐ *High Blood Pressure*	☐ *Osteoporosis*	☐ *Shingles*	☐ *Ulcers*
☐ *Asthma*	☐ *Diabetes*	☐ *Heart Attack/ Failure*	☐ *High Cholesterol*	☐ *Pain in Jaw Joints*	☐ *Sickle Cell Disease*	☐ *Sexually Transmitted Infection or Disease*
☐ *Blood Disease*	☐ *Drug Addiction*		☐ *Hives or Rash*	☐ *Parathyroid Disease*	☐ *Sinus Trouble*	
☐ *Breathing Problems*	☐ *Easily Winded*		☐ *Hypoglycemia*		☐ *Spina Bifida*	
☐ *Bruise Easily*	☐ *Emphysema*					

Please Answer YES or NO

Are you apprehensive about dental treatment?	☐ Y ☐ N	***Do you grind or clench your teeth?***	☐ Y ☐ N
Does food catch between your teeth?	☐ Y ☐ N	***Do you wear a night guard?***	☐ Y ☐ N
Are your teeth sensitive to chewing?	☐ Y ☐ N	***Do you have TMJ disorder?***	☐ Y ☐ N
Are your teeth sensitive to hot?	☐ Y ☐ N	***Are you unable to open your mouth wide?***	☐ Y ☐ N
Are your teeth sensitive to cold?	☐ Y ☐ N	***Have you had trauma to the jaw?***	☐ Y ☐ N
Do your gums feel swollen or tender?	☐ Y ☐ N	***Are you a habitual gum-chewer?***	☐ Y ☐ N
Have you ever been treated for gum disease?	☐ Y ☐ N	***Do you take fluoride supplements?***	☐ Y ☐ N
		Are you unhappy with the appearance of your teeth?	☐ Y ☐ N

Comments:

***Signature of Patient:** _____ **Printed Name:** _____ **Date:** _____*