Patient Health History

Date _____

Patient's Name _____ Date of Birth _____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING:

- Teeth sensitive to cold, heat, sweets, pressure
- Bleeding gums
  - How long?._____
- Food Impaction
- Clenching or grinding
- Clicking or popping
- Shooting pain
- Unusual sounds in ear while eating
- Burning of tongue
- Swelling or lumps in mouth
- Frequent blisters on lips or mouth
- Bad breath
- Unpleasant taste
- Unfavorable dental experience
- Complications from extractions
- Periodontal treatment
- Orthodontic treatment
- Mouth breathing
- Oral habits (nail biting, thumb sucking)
- Cigarette, Vape, Cigar, Pipe smoking

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

- Allergies to drugs _____
- Allergies to anesthetics
- Allergy to latex
- Asthma
- Seasonal allergies
- Food allergies _____
- Heart condition _____
- Heart murmur
- Rheumatic fever
- High blood pressure
- History of fainting
- Blood thinning meds _____
- Excessive bleeding from cuts or extractions
- Wounds that heal slowly
- Anemia or blood problems
- Stroke
- Headaches
- Migraines
  - How often _____
- Neurological problems
- Psychiatric care/emotional problems
- Autism
- ADHD
- Arthritis
- Respiratory disease
- Tuberculosis
- Sinus problems
- Tonsillitis
- Diabetes
- Kidney problems
- Liver problems or hepatitis
- Stomach or intestinal disease
- Ulcer or colitis
- Thyroid disorder
- Eye disorder
- Cancer _____
- Tumors, growths or malignancies
- Chemotherapy
- Radiation treatments
- Osteopenia/osteoporosis
- Bisphosphonates
- Pregnant
  - How many months _____
- AIDS
- Herpes
- Venereal Disease

What medications are you currently taking?_____

Is there any other information about your health that we should know? _____

_____