



Health History date _____

Name _____ Prefer to be called _____
 Age _____ Height _____ Weight _____
 Physician's Name _____ Physician's Phone _____

If you are taking any medications, please list the name, dosage, and reason for taking them.

Name of Medication (please include prescription and non-prescription)	Dosage (how many mg and how many times a day)	Reason for Taking

Please answer each of the following questions with yes (Y) or no (N) by checking the appropriate box.

Condition	Y	N	Comments
Are you allergic to any medications?			
Do you have an artificial heart valve, have you had Infective Endocarditis, cyanotic congenital heart disease, a congenital heart defect repaired with a prosthetic material or device, or a heart transplant that developed a valve defect?			
Do you have an artificial joint?			
Do you have high blood pressure?			
Do you have diabetes?			
Do you have or have you had Hepatitis?			
Do you have or have you had Tuberculosis (TB)?			
Do you have frequent headaches?			
Do you smoke?			
Do you chew smokeless tobacco?			
Do you drink alcohol?			
Do you suffer from any mental illness?			
Do you suffer from allergies?			
Do you suffer from chronic pain?			
Have you ever suffered from any addictions? (alcohol, prescription or non-prescription drugs)			
Have you ever had cancer of any kind?			
Have you ever been hospitalized?			
Have you had any surgeries?			
Is there a possibility you may be pregnant?			
Do you have AIDS or are you HIV+?			
Do you suffer from any illness or condition not listed here?			



Dental History Today's date _____

About when was your last dental visit? _____

Please answer each of the following questions with yes (Y) or no (N) by checking the appropriate box.

Condition	Y	N	Comments
Have you had a full series of x-rays (one of each tooth in your mouth) within the last 3 years?			
Have you had your wisdom teeth removed?			
Are any of your teeth hurting?			
Are any of your teeth sensitive to cold?			
Are any of your teeth sensitive to pressure or with chewing?			
Does your bite feel comfortable?			
Do you have discomfort in your gums?			
Do you ever have pain or tenderness in your jaw joints?			
Do you grind your teeth at night (that you are aware of)?			
Are you happy with the alignment (straightness) of your teeth?			
Are you happy with the color of your teeth?			
Is there anything you would like to change about the appearance of your teeth?			
Are you anxious or fearful about dental examinations or treatment?			
Is there anything else you would like to discuss with the doctor?			