

Health History

Ross H. Dixon DDS

Patient Name: _____ Birth Date: _____ Date: _____

Primary reason for this dental appointment: (Circle) Examination Emergency Consultation

Circle Appropriate Answer (leave blank if you do not understand question):

1. Yes No Is your general health good?
 2. Yes No Has there been a change in your health within the last year?
 3. Yes No Have you been hospitalized or had a serious illness in the last three years?
If YES, why? _____
 4. Yes No Are you being treated by a physician now? Why? _____
Date of last medical exam: _____ Date of last Dental Exam: _____
 5. Yes No Are you taking any medications or substances? Please list: _____
 6. Yes No Are you allergic to any medications, pills, or drugs?
- Please circle: Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Other _____

Dental History

7. Yes No Are you in pain now?
8. Yes No Do you have a specific dental problem? Describe _____
9. Yes No Do you have dental examinations on a routine basis? Last visit? _____
10. Yes No Do you think you have active decay or gum disease?
11. Yes No Do you brush and floss on a routine basis?
12. Yes No Do your gums ever bleed? Describe _____
13. Yes No Do you like your smile?
14. Yes No Does food catch between your teeth? Any loose teeth?
15. Yes No Do you ever have clicking, popping, or discomfort in the jaw joint? Do you brux or grind?
Approximate date of last full mouth x-rays (16 or more films) _____ Bitewing (4 films) _____

Medical History

Do you have or have you had any of the following? Please check appropriate boxes. If yes to * questions, call prior to your appointment.

Yes	No		Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	16. Heart trouble / Disease	<input type="checkbox"/>	<input type="checkbox"/>	35. Bloody stools	<input type="checkbox"/>	<input type="checkbox"/>	54. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	73. Kidney problems
<input type="checkbox"/>	<input type="checkbox"/>	17. Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	36. Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	55. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	74. Renal dialysis
<input type="checkbox"/>	<input type="checkbox"/>	18. Angina / Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	37. Anemia	<input type="checkbox"/>	<input type="checkbox"/>	56. Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>	75. Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	19. Heart attack / Failure	<input type="checkbox"/>	<input type="checkbox"/>	38. Excessive bleeding	<input type="checkbox"/>	<input type="checkbox"/>	57. Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	76. Arthritis / Gout
<input type="checkbox"/>	<input type="checkbox"/>	20. Congenital heart disorder	<input type="checkbox"/>	<input type="checkbox"/>	39. Sickle cell disease	<input type="checkbox"/>	<input type="checkbox"/>	58. Stomach disease	<input type="checkbox"/>	<input type="checkbox"/>	77. Rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	21. <i>Heart murmur</i> *	<input type="checkbox"/>	<input type="checkbox"/>	40. Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	59. Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	78. Pain in jaw joint
<input type="checkbox"/>	<input type="checkbox"/>	22. <i>Mitral valve prolapse</i> *	<input type="checkbox"/>	<input type="checkbox"/>	41. Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	60. Recent weight loss	<input type="checkbox"/>	<input type="checkbox"/>	79. Venereal disease
<input type="checkbox"/>	<input type="checkbox"/>	23. <i>Rheumatic fever</i> *	<input type="checkbox"/>	<input type="checkbox"/>	42. Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	61. Frequent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	80. AIDS / HIV+
<input type="checkbox"/>	<input type="checkbox"/>	24. <i>Artificial heart valve</i> *	<input type="checkbox"/>	<input type="checkbox"/>	43. Swelling of limbs	<input type="checkbox"/>	<input type="checkbox"/>	62. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	81. Genital herpes
<input type="checkbox"/>	<input type="checkbox"/>	25. <i>Heart pace maker</i> *	<input type="checkbox"/>	<input type="checkbox"/>	44. Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	63. Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>	82. Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	26. <i>Artificial joint</i> *	<input type="checkbox"/>	<input type="checkbox"/>	45. Breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	64. Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	83. Contact lenses
<input type="checkbox"/>	<input type="checkbox"/>	27. Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	46. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	65. Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	84. Cold sores
<input type="checkbox"/>	<input type="checkbox"/>	28. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	47. Frequent cough	<input type="checkbox"/>	<input type="checkbox"/>	66. Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	85. Fever blisters
<input type="checkbox"/>	<input type="checkbox"/>	29. Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	48. Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	67. Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>	86. Herpes
<input type="checkbox"/>	<input type="checkbox"/>	30. Blood disease	<input type="checkbox"/>	<input type="checkbox"/>	49. Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	68. Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	87. Convulsions
<input type="checkbox"/>	<input type="checkbox"/>	31. Stroke	<input type="checkbox"/>	<input type="checkbox"/>	50. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	69. Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	88. Epilepsy or seizure
<input type="checkbox"/>	<input type="checkbox"/>	32. Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	51. Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	70. Yellow jaundice	<input type="checkbox"/>	<input type="checkbox"/>	89. Fainting or dizziness
<input type="checkbox"/>	<input type="checkbox"/>	33. Unexplained fever	<input type="checkbox"/>	<input type="checkbox"/>	52. Allergies (Medicines)	<input type="checkbox"/>	<input type="checkbox"/>	71. Psychiatric care	<input type="checkbox"/>	<input type="checkbox"/>	90. Alzheimer's disease
<input type="checkbox"/>	<input type="checkbox"/>	34. Hives or rash	<input type="checkbox"/>	<input type="checkbox"/>	53. Allergies (Pollen / Dust)	<input type="checkbox"/>	<input type="checkbox"/>	72. Drug addiction	<input type="checkbox"/>	<input type="checkbox"/>	91. Tumors or growths

Yes No Have you ever had any other serious illness not checked above? Discuss _____

Yes No Do you wish to talk to the dentist privately about any problem?

Yes No Have your past experiences in a dental office always been positive?

Women (please circle) Pregnant / trying to get pregnant Nursing Taking oral contraceptives

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____

Patient Signature (parent or guardian)

Reviewed by Doctor _____ Date _____ BP _____

History review and significant findings _____

Medical Updates

Date	Exceptions	None	Patient's signature	Reviewed by
_____	_____	<input type="checkbox"/>	_____	_____
_____	_____	<input type="checkbox"/>	_____	_____
_____	_____	<input type="checkbox"/>	_____	_____
_____	_____	<input type="checkbox"/>	_____	_____
_____	_____	<input type="checkbox"/>	_____	_____