# 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 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 16. | ☐ | ☐ | Heart trouble / Disease | 35. | ☐ | ☐ | Bloody stools | 54. | ☐ | ☐ | Tuberculosis | 73. | ☐ | ☐ | Kidney problems |
| 17. | ☐ | ☐ | Irregular heart beat | 36. | ☐ | ☐ | Bruise easily | 55. | ☐ | ☐ | Cancer | 74. | ☐ | ☐ | Renal dialysis |
| 18. | ☐ | ☐ | Angina / Chest pain | 37. | ☐ | ☐ | Anemia | 56. | ☐ | ☐ | Radiation therapy | 75. | ☐ | ☐ | Thyroid Disease |
| 19. | ☐ | ☐ | Heart attack / Failure | 38. | ☐ | ☐ | Excessive bleeding | 57. | ☐ | ☐ | Chemotherapy | 76. | ☐ | ☐ | Arthritis / Gout |
| 20. | ☐ | ☐ | Congenital heart disorder | 39. | ☐ | ☐ | Sickle cell disease | 58. | ☐ | ☐ | Stomach disease | 77. | ☐ | ☐ | Rheumatism |
| **21**. | ☐ | ☐ | ***Heart murmur ** | 40. | ☐ | ☐ | Hemophilia | 59. | ☐ | ☐ | Ulcers | 78. | ☐ | ☐ | Pain in jaw joint |
| **22**. | ☐ | ☐ | ***Mitral valve prolapse ** | 41. | ☐ | ☐ | Leukemia | 60. | ☐ | ☐ | Recent weight loss | 79. | ☐ | ☐ | Venereal disease |
| **23**. | ☐ | ☐ | ***Rheumatic fever ** | 42. | ☐ | ☐ | Blood transfusion | 61. | ☐ | ☐ | Frequent diarrhea | 80. | ☐ | ☐ | AIDS / HIV+ |
| **24**. | ☐ | ☐ | ***Artificial heart valve ** | 43. | ☐ | ☐ | Swelling of limbs | 62. | ☐ | ☐ | Diabetes | 81. | ☐ | ☐ | Genital herpes |
| **25**. | ☐ | ☐ | ***Heart pace maker ** | 44. | ☐ | ☐ | Lung disease | 63. | ☐ | ☐ | Excessive thirst | 82. | ☐ | ☐ | Glaucoma |
| **26**. | ☐ | ☐ | ***Artificial joint ** | 45. | ☐ | ☐ | Breathing problems | 64. | ☐ | ☐ | Hypoglycemia | 83. | ☐ | ☐ | Contact lenses |
| 27. | ☐ | ☐ | Heart surgery | 46. | ☐ | ☐ | Shortness of breath | 65. | ☐ | ☐ | Liver disease | 84. | ☐ | ☐ | Cold sores |
| 28. | ☐ | ☐ | High blood pressure | 47. | ☐ | ☐ | Frequent cough | 66. | ☐ | ☐ | Hepatitis A | 85. | ☐ | ☐ | Fever blisters |
| 29. | ☐ | ☐ | Low blood pressure | 48. | ☐ | ☐ | Hay fever | 67. | ☐ | ☐ | Hepatitis B or C | 86. | ☐ | ☐ | Herpes |
| 30. | ☐ | ☐ | Blood disease | 49. | ☐ | ☐ | Sinus trouble | 68. | ☐ | ☐ | Night sweats | 87. | ☐ | ☐ | Convulsions |
| 31. | ☐ | ☐ | Stroke | 50. | ☐ | ☐ | Asthma | 69. | ☐ | ☐ | Dry mouth | 88. | ☐ | ☐ | Epilepsy or seizure |
| 32. | ☐ | ☐ | Scarlet Fever | 51. | ☐ | ☐ | Emphysema | 70. | ☐ | ☐ | Yellow jaundice | 89. | ☐ | ☐ | Fainting or dizziness |
| 33. | ☐ | ☐ | Unexplained fever | 52. | ☐ | ☐ | Allergies (Medicines) | 71. | ☐ | ☐ | Psychiatric care | 90. | ☐ | ☐ | Alzheimer's disease |
| 34. | ☐ | ☐ | Hives or rash | 53. | ☐ | ☐ | Allergies (Pollen / Dust) | 72. | ☐ | ☐ | Drug addiction | 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 | | Patient's signature | Reviewed by |
|---|---|---|---|---|
| _____ | _____ | None ☐ | _____ | _____ |
| _____ | _____ | None ☐ | _____ | _____ |
| _____ | _____ | None ☐ | _____ | _____ |
| _____ | _____ | None ☐ | _____ | _____ |
| _____ | _____ | None ☐ | _____ | _____ |