

## DENTAL HEALTH HISTORY

**Please mark any that apply:**

Are you apprehensive about dental treatment? Y N

If so, what is your biggest concern? \_\_\_\_\_  
 \_\_\_\_\_

Have you had problems with previous dental treatment? Y N

If so, please describe. \_\_\_\_\_

Do you gag easily? Y N

Do your gums bleed or hurt when you brush or floss? Y N

How often do you brush? \_\_\_\_\_

How often do you floss? \_\_\_\_\_

Do you clench or grind your teeth while awake / asleep? Y N

Do you have clicking or popping when opening or closing? Y N

Do you have pain of joint, ear, or side of face? Y N

Do you feel pain when your teeth come in contact with:  
 Hot foods or liquids? Y N

Cold foods or liquids? Y N

Sweets? Y N

Do you experience chewing sensitivity? Y N

Does food catch between your teeth? Y N

## MEDICAL HEALTH HISTORY

**Do you have, or have you had, any of the following:**

<p><b>Heart Problems</b> <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Chest pain <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Shortness of breath <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Blood pressure problem <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Heart murmur <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Attack <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Heart valve problem <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Taking heart medication <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Rheumatic fever <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Pacemaker <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Artificial heart valve <span style="float: right;">Y N</span></p> <p><b>Blood Problems</b> <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Abnormal bleeding <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Blood disease (anemia) <span style="float: right;">Y N</span></p> <p><b>Allergy Problems</b> <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Hay fever <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Sinus problems <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Skin rashes <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Taking allergy medication <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma <span style="float: right;">Y N</span></p> <p><b>Are you allergic, or have you reacted adversely, to any of the following?</b> <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Local anesthetics ("Novocaine") <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Penicillin or other antibiotics <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Sulfa drugs <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Barbiturates, sedatives, or sleeping pills <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Aspirin, Acetaminophen, or Ibuprofen <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Codeine, Demerol, or other narcotics <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Reaction to metals <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Latex or rubber dam <span style="float: right;">Y N</span></p> <p>Other _____ <span style="float: right;">Y N</span></p> <p>Notes: _____</p> <p>_____</p> <p>_____</p>	<p><b>Intestinal Problems</b> <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Ulcers <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Weight gain or loss <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney or bladder problems <span style="float: right;">Y N</span></p> <p><b>Bone or Joint Problems</b> <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Arthritis <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Back or neck pain <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Joint replacement <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> (e.g. total hip, pins, or implants) <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Fainting Spells, Seizures, or Epilepsy <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Stroke(s) <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Frequent or severe headaches <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Thyroid problems <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Persistent cough or swollen glands <span style="float: right;">Y N</span></p> <p><b>Premedications required by physician</b> <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer/Tumor <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Tuberculosis or other respiratory disease <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Do you smoke? <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> If so, how much? _____ <span style="float: right;">Y N</span></p>
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<p><b>Diabetes</b> <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Urinate more than 6 times a day <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Thirsty or mouth is dry much of the time <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Family history of diabetes <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis, jaundice, or liver trouble <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Herpes or other STD <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> HIV-positive/AIDS <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Glaucoma <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Do you wear contact lenses? <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> History of head injury? <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Epilepsy or other neurological disease? <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> History of alcohol or drug abuse? <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Do you have any disease, condition, or problem not listed previously that you feel we should know about? <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> If so, please describe _____ <span style="float: right;">Y N</span></p> <p>_____ <span style="float: right;">Y N</span></p>	<p><b>During the past 12 months, have you taken any of the following?</b> <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Antibiotics or sulfa drugs <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Anticoagulants (e.g., Coumadin) <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> High blood pressure medicine <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Osteoporosis medication <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Tranquilizers <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Insulin, Orinase, or similar drug <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Aspirin (daily) <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Digitalis or drugs for heart trouble <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Nitroglycerin <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Cortisone (steroids) <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Natural remedies <span style="float: right;">Y N</span></p> <p><input type="checkbox"/> <input type="checkbox"/> Nonprescription drug/supplements <span style="float: right;">Y N</span></p> <p>Other _____ <span style="float: right;">Y N</span></p> <p>_____</p> <p>_____</p>
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I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize Dr. Hodge and/or dental staff to perform all necessary dental services that I may need. I understand that I am responsible for payment of services rendered and also responsible for paying any unpaid portion that my insurance does not cover.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Notes: \_\_\_\_\_

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