Do you smoke or use chewing tobacco?       P (s)       No       Are you interested in stopping?       YES NO SOMEWHAD         Do you have areas where food gets trapped/collects between teeth?       P (s)       No       No         Do you have areas where food gets trapped/collects between teeth?       P (s)       No       No         B ad Breath       Bleding Gums       Blitters on lips/mouth       Clicking /Popping of Jaw       Dry Mou         B ad Breath       Bleding Gums       Blitters on lips/mouth       Clicking /Popping of Jaw       Dry Mou         B ad Breath       Bleding Gums       Balters on lips/mouth       Clicking /Popping of Jaw       Dry Mou         B ad Breath       Bleding Gums       Canker SO       Sensitive to Biting       Periodontal (gum) Treatment       Othedontic Treatment       Other	Dental History Reason for Today's Visit: Former Dentist: City/State:		Last Dental Cleaning Last Dental X-Ray:		
Bad Breath       Bleding Gums       Bisters on lips/mouth       □ Citking /Popping of Jaw       □ Dry Mouth         Grinding Teeth       □ Sensitive to biting       □ Periodontal (gum) Treatment       □ Orthodontic Stepporosis (bone density) medicine         U = V       N       N Heart Disease       □ Orthodontic Stepporosis (bone density) medicine       □ Orthodontic Stepporosis (bone density) medicine         U = N       N Mitral Valve Prolapse       <	Do you smok Do you have	e or use chewing tobacco?  Yes No areas where food gets trapped/collects between teeth	How often do you floss? □ 1x day □ 2x day □ Are you interested in stopping? YES NO SOMEWHAT Are Yes □ No		
Y       N       ARTIFICIAL JOINTS         B       Knee       Hip       Heart Valve       Other         Date of replacement:	<ul> <li>Bad Breat</li> <li>Grinding 1</li> </ul>	h 🛛 Bleeding Gums 📮 Blisters on lips/n Feeth 🗳 Sensitivity to Cold 📮 Sensitive to Heat	nouthClicking /Popping of JawDry MouthSensitive to SweetsCanker Sores		
□ Y □ N       ARTIFICIAL JOINTS       Aspirin         □ Knee □ Hip □ Heart Valve □ Other	MEDIC	CAL HEALTH HISTORY			
□ Knee □ Hip □ Heart Valve □ Other		ARTIFICIAL JOINTS			
Date of replacement:   Surgeon:   Do you require Pre-Medication before Dental Visits?   Do you require Pre-Medication before Dental Visits?   P   N   Congenital Heart Lesions   P   N   Y   N   High Blood Pressure   Y   N   Y   N   Y   N   Y   N   Y   N   High Blood Pressure   Y   N   Y   N   Y   N   N Hepatitis   Y   N   N High Blood Pressure   Penicillin or other Antibiotics   Later   Y   N   N Kidney Disease   Y   N   Y   N   Y   N   N Altibor HiV   Y   N   Y   N   N Atliteon/Chemotherapy Treatment   Y   N   Y   N   Y   N   N Herpes/Cold Sores   Y   N   Y   N   Y   N   N Herpes/Cold Sores   Y   N   Y   N   Y   N   N Herpes/Cold Sores   Y   N <td< td=""><td></td><td></td><td colspan="3"></td></td<>					
Do you require Pre-Medication before Dental Visits?       □Y □N       Antidepressants or tranquilizers         □Y □N       Congenital Heart Lesions       Insulin, Orinase, or other diabetes drug         □Y □N       Stroke       Date:         □Y □N       Note the end of					
Y       N       Congenital Heart Lesions       Insulin, Orinase, or other diabetes drug         Y       N       Stroke       Date:	Sur				
□ Y □ N       Congenital Heart Lesions       Nitroglycerin         □ Y □ N       Stroke Date:       Cortisone or other steroids         □ Y □ N       Mitral Valve Prolapse       Osteoporosis (bone density) medicine         □ Y □ N       Heart Murmur       List All Other Medications:         □ Y □ N       N fliph Blood Pressure       List All Other Medications:         □ Y □ N       High Blood Pressure       Please ✓ or list any Allergies to material/medicin         □ Y □ N       High Blood Pressure       Please ✓ or other narcotics         □ Y □ N       Hopatitis Type:       Local anesthetics ("Novocain")       Sulfa         □ Y □ N       N kidney Disease       Dother Antibiotics       Latex         □ Y □ N       Liver Disease       Other Allergies:       Aspir         □ Y □ N       AIDS or HIV       Name of Physician:       Physician Phone #:         □ Y □ N       Radiation/Chemotherapy Treatment       Physician Phone #:       Pharmacy:         □ Y □ N       N therpes/Cold Sores       Frequency:       Pharmacy Phone #:         □ Y □ N       Alcohol/Chemical Dependency       Pharmacy Phone #:       Pharmacy Phone #:	Do you requ	ure Pre-Medication before Dental Visits?			
Y N Stroke Date: Cortisone or other steroids   Y N Mitral Valve Prolapse Osteoporosis (bone density) medicine   Y N Heart Murmur List All Other Medications:   Y N Scarlet Fever   Y N Pacemaker   Y N Heart Disease   Y N Heart Disease   Y N Heart Disease   Y N Heart Disease   Y N Hepatitis   Y N N   Y N N   Y N N   Y N N   Y N N   Y N N   Y N Hepatitis   Y N N   Y N N   Dy N Kidney Disease   Y N N   Y		Congenital Heart Lesions			
Y □ N       Heart Murmur       List All Other Medications:         Y □ N       Scarlet Fever         Y □ N       Pacemaker         Y □ N       Heart Disease         Y □ N       Heart Disease         Y □ N       Heart Disease         Y □ N       High Blood Pressure         Y □ N       Low Blood Pressure         Y □ N       Heart Type:         Y □ N       Heart Type:         Y □ N       Diabetes         Y □ N       Nidney Disease         Y □ N       Liver Disease         Y □ N       Liver Disease         Y □ N       AIDS or HIV         Y □ N       Radiation/Chemotherapy Treatment         Y □ N       Thyroid Problems         Y □ N       Herpes/Cold Sores         Y □ N       Alcohol/Chemical Dependency         Y □ N       Alcohol/Chemical Dependency         Y □ N       Name of Person Completing form					
Y N Scarlet Fever   Y N Pacemaker   Y N Heart Disease     Y N Anemia   Y N High Blood Pressure   Y N Low Blood Pressure   Y N Low Blood Pressure   Y N Low Blood Pressure   Y N Hepatitis   Y N N   Y N N   Y N N   Y N N   Y N N   Y N N   Y N N   Y N N   Y N N   Y N N   Y N N   Y N N   Y N N   Y N N   Y N N   Y N N   Y N N   N N   Y N N   Y N N   N N   Y N   N N   N N   N N   N N   N N   N N   N N   N N   N N   N N   N N   N N   N N   N N   N N   N N   N N   N N			Osteoporosis (bone density) medicine		
Y N   Y N   Heart Disease     Y N   Y N   Y N   Y N   High Blood Pressure   Y N   Y N   Hepatitis Type:			List All Other Medications:		
Y N       Heart Disease         Y N       Anemia         Y N       High Blood Pressure         Y N       Low Blood Pressure         Y N       Hepatitis Type:         Y N       Diabetes Type:         Y N       Kidney Disease         Y N       Liver Disease         Y N       AIDS or HIV         Y N       Radiation/Chemotherapy Treatment         Y N       N Radiation/Chemotherapy Treatment         Y N       N Thyroid Problems         Y N       Tuberculosis         Y N       Preferred Pharmacy:         Y N       Pharmacy Phone #:         Y N       N Alcohol/Chemical Dependency         Y N       N Abnormal bleeding af					
Y □ N       Anemia         Y □ N       High Blood Pressure         Y □ N       Low Blood Pressure         Y □ N       Liver Disease         Y □ N       Liver Disease         Y □ N       AIDS or HIV         Y □ N       Radiation/Chemotherapy Treatment         Y □ N       Name of Physician:         Y □ N       Thyroid Problems         Y □ N       Tuberculosis         Y □ N       Pregnant         Y □ N       Alcohol/Chemical Dependency         Y □ N       Alcohol/Chemical Dependency         Y □ N       Alcohol/Chemical Dependency         Y □ N       Name of Person Completing form					
Image: Anenia       Image: Anenia         Image: Y low High Blood Pressure       Piease Image: Anenia         Image: Y low Blood Pressure       Please Image: Anenia         Image: Y low Blood Pressure       Image: Anenia         Image: Y low Blood Presses       Image: Anenia         Image: Y low Blood Presses       Other Allergies: Image: Aspir         Image: Y low Blood Presses       Other Allergies: Image: Image			ALL FRGIES		
Y       N       Low Blood Pressure       Penicillin or other Antibiotics       Latex         Y       N       Hepatitis       Type:					
Y       N       Hepatitis       Type:       Local anesthetics ("Novocain")       Sulfa         Y       N       Diabetes       Type:       Codeine or other narcotics       Aspir         Y       N       Kidney Disease       Barbiturates (sleeping pills)_       Other Allergies:       Other Allergies:       Other Allergies:         Y       N       AIDS or HIV       N       Name of Physician:       Physician Phone #:					
Y       N       Diabetes       Type:					
Y       N       Liver Disease       Other Allergies:	🗆 Y 🗖 N	Diabetes Type:	Codeine or other narcotics Aspirin		
Y       N       AIDS or HIV         Y       N       Cancer       Type:         Y       N       Radiation/Chemotherapy Treatment       Name of Physician:         Y       N       Radiation/Chemotherapy Treatment       Physician Phone #:         Y       N       Tuberculosis       Preferred Pharmacy:         Y       N       Herpes/Cold Sores       Frequency:         Y       N       Pregnant       Due Date:         Y       N       Alcohol/Chemical Dependency       Pharmacy Phone #:         Y       N       Alcohol/Chemical Dependency       Printed Name of Person Completing form					
Y       N       Cancer       Type:			Other Allergies:		
Y       N       Radiation/Chemotherapy Treatment       Physician Phone #:         Y       N       Thyroid Problems       Preferred Pharmacy:         Y       N       Tuberculosis       Preferred Pharmacy:         Y       N       Herpes/Cold Sores       Frequency:         Y       N       Pregnant       Due Date:         Y       N       Alcohol/Chemical Dependency         Y       N       Abnormal bleeding after extractions or surgery?         Printed Name of Person Completing form					
<ul> <li>Y N Thyroid Problems</li> <li>Y N Tuberculosis</li> <li>Y N Herpes/Cold Sores Frequency:</li> <li>Y N Pregnant Due Date:</li> <li>Y N Alcohol/Chemical Dependency</li> <li>Y N Abnormal bleeding after extractions or surgery?</li> <li>Printed Name of Person Completing form</li> </ul>		Cancer Type:			
<ul> <li>Y N Tuberculosis</li> <li>Y N Herpes/Cold Sores Frequency:</li> <li>Y N Pregnant Due Date:</li> <li>Y N Alcohol/Chemical Dependency</li> <li>Y N Abnormal bleeding after extractions or surgery?</li> <li>Preferred Pharmacy:</li> <li>Pharmacy Phone #:</li> </ul>			Physician Phone #:		
□ Y □ N       Herpes/Cold Sores       Frequency:       Pharmacy Phone #:         □ Y □ N       Pregnant       Due Date:       Pharmacy Phone #:         □ Y □ N       Alcohol/Chemical Dependency       Pharmacy Phone #:         □ Y □ N       Alcohol/Chemical Dependency       Pharmacy Phone #:         □ Y □ N       Alcohol/Chemical Dependency       Printed Name of Person Completing form			Preferred Pharmacy:		
<ul> <li>□ Y □ N Pregnant Due Date:</li> <li>□ Y □ N Alcohol/Chemical Dependency</li> <li>□ Y □ N Abnormal bleeding after extractions or surgery?</li> <li>Printed Name of Person Completing form</li> </ul>		Herpes/Cold Sores Frequency:	Pharmacy Phone #:		
□ Y □ N Abnormal bleeding after extractions or surgery? Printed Name of Person Completing form		Pregnant Due Date:			
Printed Name of Person Completing form		Alcohol/Chemical Dependency			
		bhormal dieeding after extractions or surgery?	Printed Name of Person Completing form		
	Please note a	ny condition, disease or medical problem not listed?	completing form		
Signature of Person Completing form			Signature of Person Completing form Da		

## STOP Please do not write in this area. This is for our Staff to update your Health History on future Dental Visits.

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-	SIOP Please do not write in this dred.	inis is	<u>tor o</u>	ļ
	Today's Date: Changes to your Health History as noted above?	Y Y	N	
	Are you taking any new medications?	Y	N	

**Signature of Patient** 

Signature of Patient

Today's Date:\_

Are you taking any new medications?

Changes to your Health History as noted above?

Y N

Y N