Health History

Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Do you need assistance/support while in treatment room? _____

Reason for Office Visit ?_____ Last Dental Visit? _____

Do you have any dental discomfort to: ☐ HEAT ☐ COLD ☐ SWEETS ☐ PRESSURE ☐ Other _____

Are you frightened during dental visits? ☐ Yes ☐ No Do you gag easily? ☐ Yes ☐ No

Do you have pain, clicking or popping when opening your jaw? ☐ Yes ☐ No

ARE YOU HAPPY WITH YOUR SMILE? ☐ Yes ☐ No what would you like to change? _____

Medical History

CONDITIONS

Y	N	
☐	☐	**Abnormal Bleeding**
☐	☐	**Anemia**
☐	☐	**Angina Pectoris**
☐	☐	**Arthritis**
☐	☐	**Asthma**
☐	☐	**Cancer/Chemo** _____
☐	☐	**Diabetes I II**
☐	☐	**Drug abuse/alcoholism**
☐	☐	**Emphysema**
☐	☐	**Epilepsy**
☐	☐	**Fainting Spells**
☐	☐	**Glaucoma**
☐	☐	**HIV/AIDS**
☐	☐	**Heart Disease**
☐	☐	**Heart Murmur**
☐	☐	**Heart Surgery**
☐	☐	**Hemophilia**
☐	☐	**Hepatitis A or B or C**
☐	☐	**High Blood Pressure**
☐	☐	**Kidney Disorder**
☐	☐	**Liver Disease**
☐	☐	**Mitral Valve Prolapse**
☐	☐	**Pace Maker**
☐	☐	**Psychiatric Treatment**
☐	☐	**Rheumatic Fever**
☐	☐	**Seizures**
☐	☐	**Shingles/Herpes**
☐	☐	**Sickle Cell Disease**
☐	☐	**Stroke**
☐	☐	**Thyroid Problems**
☐	☐	**Tuberculosis**
☐	☐	**Ulcers**
☐	☐	**Other** _____

ALLERGIES

Y	N	
☐	☐	**Aspirin**
☐	☐	**Codeine**
☐	☐	**Dental Anesthetics**
☐	☐	**Erythromycin**
☐	☐	**Jewelry**
☐	☐	**Latex**
☐	☐	**Metals**
☐	☐	**Penicillin**
☐	☐	**Seasonal/Food** _____
☐	☐	**Tetracycline**
☐	☐	**Other** _____

HAVE YOU EVER:

***had a HIP/KNEE/JOINT replacement?**

☐ **Yes** ☐ **No when?** _____

***taken Fen-Phen? (Weightloss drug)**

☐ **Yes** ☐ **No**

***taken Biophosphonate/Fosomax?**

☐ **Yes** ☐ **No** _____

***Smoked or used Tobacco?**

☐ **Yes** ☐ **No**

Quit when?_____

IF YOU ARE FEMALE

Y	N	
☐	☐	**Do you take Birth Control Pill**
☐	☐	**Are you pregnant? _____wk #**
☐	☐	**Are you nursing?**

LIST MEDICATIONS

(We will scan your list if it's long)

_____

_____

_____

_____

_____

PHYSICIAN NAME

_____

Phone # _____

PREFERRED PHARMACY

_____

Phone # _____

Jacqueline Bennett D.D.S
Art Of Dentistry

*My Signature below indicates that the **above information is accurate***

Signature _____*Date* _____

*Relationship to patient:*_____

Reviewed By: _____*DATE*_____

Updated By: _____*DATE*_____