

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 _____

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 # _____

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? _____



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 _____