Holly Springs Family Dentistry

Health History

Name _____ Birth date _____ Age _____

Why are you seeking dental treatment?

Please answer each question. Check yes or no. If in doubt, leave blank	YES / NO
1. Are you in good health now.....	Y/N
2. Are you now under the care of a physican.....	Y/N
If so, what is the condition being treated? _____	
3. Have you ever been hospitalized or had a serious illness?	Y/N
If yes ,explain _____	
4. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than they have in the past ?.....	Y/N
5. (Women) Are you pregnant? If so, give due date.....	Y/N
6. Do you use tobacco in any form? If yes, how much.....	Y/N
7. Do you use alcoholic beverages (more than 2 drinks per day)?.....	Y/N

8. Do you have or have you ever had any of the following?

GENERAL	**Yes/No**	**HEART/BLOOD VESSELS**	**Yes/No**
Tire easily, weakness	Y/N	Rheumatic fever	Y/N
Marked weight change	Y/N	Heart Murmur	Y/N
Night sweats	Y/N	Chest pain/ discomfort	Y/N
Persistent fever	Y/N	Heart attack/ trouble	Y/N
SKIN		Shortness of breath	Y/N
Eruptions (rash) hives	Y/N	Swelling of ankles	Y/N
Changes in skin color	Y/N	High Blood pressure	Y/N
EYES		Congenital heart disease	Y/N
Visual change	Y/N	Mitral valve prolapse	Y/N
Glaucoma	Y/N	Artifical heart valve	Y/N
EARS		Pacemaker	Y/N
Loss of hearing	Y/N	Heart Surgery	Y/N
Ringing in ears	Y/N	High Cholesterol	Y/N
NOSE		**BONES/MUSCLES**	
Frequent nosebleeds	Y/N	Arthritis/rheumatism	Y/N
Sinus problems	Y/N	Artifical joint/limbs	Y/N
THROAT		**DIGESTIVE SYSTEM**	
Soreness/Hoarseness	Y/N	Hepatitis	Y/N
NERVOUS SYSTEM		Jaundice	Y/N
Stroke	Y/N	Ulcers	Y/N
Headaches	Y/N	Change in appetite	Y/N
Convulsions/epilespy	Y/N	Black, bloody or pale stools	Y/N
Numbness/tingling	Y/N	**URINARY**	
Dizziness/fainting	Y/N	Kidney disease	Y/N
Psychiatric treatment	Y/N	Increase in frequency of urination (night)	Y/N
RESPIRATORY		Burning on urination	Y/N
Tuberculosis	Y/N	Urethral discharge	Y/N
Emphysema	Y/N	Bloody urine	Y/N
Asthma/Hayfever	Y/N	Venereal disease	Y/N
Persistent cough	Y/N	**BLOOD**	
Sputum production	Y/N	Bruise easily	Y/N
Cough up bloody sputum	Y/N	Anemia	Y/N
Difficulty breathing while lying down	Y/N	Blood tranfusion	Y/N
ENDOCRINE		**OTHER**	
Diabetes	Y/N	Radiation Therapy	Y/N
Family History of diabetes	Y/N	Chemotherapy	Y/N
Thyroid Condition/goiter	Y/N	Tumors or Growths	Y/N
Other	Y/N	Cancer	Y/N

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9. Are you ALLERGIC or have you ever experienced any reaction to the following?

	Yes/No		Yes/No
Local anesthetics (e.g. novocaine)	Y/N	Aspirin or codeine	Y/N
Barbiturates/sedatives/sleeping pills	Y/N	Sulfa drugs	Y/N
Penicillin/ other antibiotics	Y/N	Other allergies	Y/N

10. Are you taking any of the following?

Antibiotics/sulfa drugs	Y/N	Tranquilizers	Y/N
Blood thinners	Y/N	Insulin/other diabetes drugs	Y/N
Blood pressure medication	Y/N	Recreational drugs	Y/N
Thyroid medicine	Y/N	Digitalis/other heart medications	Y/N
Cortisone/steroids	Y/N	Nitroglycerin	Y/N
Antihistamines/allergy drugs	Y/N	Aspirin	Y/N
Cold remedies	Y/N		

Other medications please list

1.....

2.....

3.....

4.....

11. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so explain.

.....

.....

12.Physician's Name.....Phone.....

13. Have you ever had serious trouble associated with previous dental treatment?.....

.....

14. Does dental treatment make you nervous?

No.....Slightly.....Moderately..... Extremely.....

Date of last dental visit.....

15. Have you ever been treated for periodontal disease (gum disease,pyorrhea,trench mouth)? Y/N

16. Do you have or have you ever had any of the following?

	Yes/No		
Bleeding,sore gums	Y/N	Loose teeth	Y/N
Unpleasant taste/bad breath	Y/N	Sensitive to hot	Y/N
Burning tongue	Y/N	Sensitive to cold	Y/N
Frequent blisters, lips/mouth	Y/N	Sensitive to sweets	Y/N
Swelling/lumps in mouth	Y/N	Sensitive to biting	Y/N
Ortho treatment	Y/N	Food impaction	Y/N
Biting cheeks/lips	Y/N	Clenching/grinding	Y/N
Clicking/popping jaw	Y/N	Shifting of teeth	Y/N
Difficulty opening/closing jaw	Y/N	Change in bite	Y/N

17. Do you use the following?

Brush	Y/N
Dental floss	Y/N
Fluoride rinse	Y/N
Mouth rinse (Act,Listerine,Scope, etc)	Y/N

Signature.....Date.....