Dentist South Shore Health History Form

Full Name: _____
Date of Birth: _____

Medication List:

Please list any prescription or over the counter medications:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Dental History:

Please check the box if the question applies to you.

- Do your gums bleed with brushing or flossing?
- Are your teeth sensitive to hot or cold?
- Does food or floss catch between your teeth?
- Is your home water supply fluoridated?
- Do you drink bottled or filtered water?
- Do you wear partials or dentures?
- Do you clench your teeth?
- Do you grind your teeth?
- Are you currently experiencing dental pain or discomfort?
- Do you now or have you ever had:
    - Periodontal (gum) treatment
    - Orthodontia (braces)
    - Problems with previous dental treatment
    - Serious injury to your head, neck, or mouth
    - Ear aches or neck pains
    - Sores or ulcers in your mouth
    - Clicking, popping, or any jaw discomfort

Do you like your smile? _____
If no, what would you like to change?

_____

Allergies:

- Penicillin or Amoxicillin
- Clindamycin
- Local Anesthetic
- Acetaminophen (Tylenol)
- Acrylic
- Aspiring
- Codeine
- Demerol
- Erythromycin
- Fluoride
- Ibuprofen (Motrin/Advil)
- Iodine
- Latex
- Morphin
- Sulfa
- Tetracyline
- Hay FEver/Seasonal
- Food: Please List

  _____
- Other: Please List

  _____

Preferred Pharmacy Name and Phone Number:

_____

Date of Last Physical Exam: ____/ _____/ _____

Medical History Questionnaire:

- Do you drink alcoholic beverages?
- Do you use tobacco? (smoking, snuff, chew)

  _____
- Do you use any tobacco cessation products? (patch, gum, medication) _____
- Do you have sleep apnea? If yes, are you treating it? _____
- Has there been any changes to your general health in the last year? Please explain:

  _____

  _____
- Are you pregnant?
- Are you nursing?
- Are you taking birth control or hormone replacements?
- Have you had any serious illness, surgeries, or been hospitalized in the last 5 years? Please explain and include dates if possible:

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_____

- Have you had any adverse reactions to medications or injections? Please explain:

  _____

  _____
- Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?
- Has your physician recommended that you take antibiotics prior to your dental treatment? Please explain: _____

Please check if you have had any of the following conditions:

- Aids or HIV Infection
- Alzheimer's/Dementia
- Anemia
- Angina
- Anxiety
- Arthritis
- Artificial Joint _____
- Asthma
- Autoimmune disease
- Back problems
- Bleeding disorder/excessive bleeding
- Blood disease
- Blood transfusion
- Breathing problems/respiratory disease
- Cancer/Chemotherapy/Radiation. If yes, please list date, type, and location of radiation:

  _____
- Cardiovascular disease
- Chest pain on exertion
- Congestive heart failure
- Damaged heart valves
- Diabetes
- Hypoglycemia
- Eating disorder
- Emphysema
- Epilepsy
- Fainting spells
- Seizures. If yes, how often and what type?

  _____
- Frequent headaches/Migraines
- Acid Reflux or Heartburn
- Glaucoma
- Gout
- Hearing difficulties
- Heart attack
- Heart Murmur
- Heart Rhythm Disorder
- Congenital Heart Defects. If yes, please explain: _____
- Hepatitis, Jaundice, Liver Disease
- High Blood Pressure
- Low Blood PRessure
- Kidney Problems
- Low Pain Tolerance
- Malnutrition
- Mitral Valve Prolapse
- Neurological Disorders. If yes, please explain:

  _____
- Night Sweats
- Osteoporosis/Paget's Disease
- Pacemaker
- Persistent Swollen Glands in Neck
- Psychiatric Care. If yes, please explain:

  _____
- Recurrent Infections
- Rheumatic Heart Disease
- Rheumatoid ARthritis
- Severe or rapid weight loss
- Sexually transmitted infection or disease
- Sinus trouble
- Stroke. If yes, please explain: _____

  _____
- Systemic Lupus Erythematosus
- Thyroid Disorder
- TMJ Disorder
- Tuberculosis
- Tumors or Growths
- Ulcers