**Health History**

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last Physical Exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**In case of Emergency, notify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Nearest Relative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_**

**Do you have or have had any of the following? Please Circle Yes or No**

Hypoglycemia, Diabetes Yes/No Aids Exposure Yes/No Heart Attack, Heart Trouble Yes/No

Circulatory Problems Yes/No Hay Fever, Asthma Yes/ No Mitral Valve Prolapse Yes/No

Excessive Bleeding Yes/No Epilepsy, Seizers Yes/No Artificial Heart Valves Yes/No

Anemia, Blood Disorder Yes/No Hepatitis, Jaundice Yes/No Heart Murmur Yes/No

Lung Problems Yes/No Fainting, Blackouts Yes/No Artificial Joints Yes/No

Nervous Disorder Yes/No Blood Transfusion Yes/No High Blood Pressure Yes/No

Facial or Head Injuries Yes/No Kidney Problems Yes/No Rheumatic Fever Yes/No

Glaucoma, Eye Problems Yes/No Malignancies, Cancer Yes/No Ulcer, Digestive Problems Yes/No

Sinus Problems Yes/No Are you Pregnant? Yes/No Stroke Yes/No

Headaches, Migraines Yes/No Radiation Treatment Yes/No Thyroid Problems Yes/No

Heart Pacemaker Yes/No Other Yes/No Drug Use Yes/No

**Have you been hospitalized in the last 2 years?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes please Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you have unfavorable reactions to any of the following. Please circle Yes or No**

Aspirin: Yes/No Codeine: Yes/No Anesthetics: Yes/No Novocaine: Yes/No

Sedatives: Yes/No Sulfa: Yes/No Penicillin: Yes/No Other: Yes/No

**Please list any medications you are currently taking:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of last dental visit \_\_\_\_\_\_\_\_Date of last cleaning \_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of last set of full x-rays \_\_\_\_\_\_**

**Name of last Dentist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_May we have records released Yes/No**

**How often do you brush?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often do you floss?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you smoke/Chew tobacco? Yes/No how often \_\_\_\_\_\_Do You Drink alcohol? Yes/No How often\_\_\_\_\_\_**

**Do you Snore? Yes/No**

**Have you noticed any of the following? Please Circle Yes or No**

Loss of teeth? Yes/No Teeth tender to chew on? Yes/No Discomfort in face, head or neck? Yes/No

Bleeding Gums? Yes/No Food caught between teeth? Yes/No Sensitivity to sweets? Yes/No

Grinding teeth? Yes/No Hot and cold sensitivity? Yes/No Jaw clicking or popping? Yes/No

Sores in mouth? Yes/No Swelling, or lumps in mouth? Yes/No Do you clench your teeth? Yes/No

**Have you ever had periodontal treatment (deep cleaning)? Yes/No If yes how long ago?\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever had any problems with dental treatment? Yes/No If yes, How long ago?\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**The Information above is correct to the best of my knowledge. I give consent to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. I also authorize the doctor and her staff to perform dental treatment indicated by the diagnosis.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient or Parent/ Guardian Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Anita Paulus, D.D.S., P.C. (Dentist) Date**

**Blood pressure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pulse\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Initials\_\_\_\_\_\_\_\_**

**Oral Cancer Screen Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Initials\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ASA Classification \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_Initials\_\_\_\_\_\_\_\_\_\_\_\_\_\_**