

## Health history form

Marital Status  Decupation  Employer  Diver's License #  Nork Schedule  Emergency Contact Name  Emergency Contact Name  Emergency Contact Phone #  Nould you like to receive text messages regarding  eminders on your appointments,  O Yes O No  Cell Phone #:  Now did you hear about us?  When was your last dential appointment?  Why did you leave your last dentist?  Who is financially responsible for your dental investment?  WE WANT TO TAKE CARE OF YOUR NEEDS  Fell us about your current dental problems:  O you avoid brushing any part of your mouth?  O you avoid brushing any part of your mouth?  O you avoid brushing any part of your mouth?  O you avoid brushing any part of your mouth?  O you avoid brushing any part of your mouth?  O you avoid brushing any part of your mouth?  O you avoid brushing any part of your mouth?  O yes O No  **  Yes O No  **  I would like my teeth whiter:  O yes O No  **  Would like my teeth whiter:  O yes O No  **  Would like to repair chips in my teeth:  O yes O No  **  Would like to repair chips in my teeth:  O yes O No  **  Would like to repair chips in my teeth:  O yes O No  **  Would like to repair chips in my teeth:  O yes O No  **  Would like to repair chips in my teeth:  O yes O No  **  Would like to repair chips in my teeth:  O yes O No  **  Would like to repair chips in my teeth:  O yes O No  **  Would like to repair chips in my teeth:  O yes O No  **  Would like to repair chips in my teeth:  O yes O No  **  Would like to repair chips in my teeth:  O yes O No  **  Would like to repair chips in my teeth:  O yes O No  **  Would like to repair chips in my teeth:  O yes O No  **  Would like to repair chips in my teeth:  O yes O No  **  Would like to repair chips in my teeth:  O yes O No  **  Would like to repair chips in my teeth:  O yes O No  **  Would like to repair chips in my teeth:  O yes O No  **  Would like to repair chips in my teeth:  O yes O No  **  Would like to repair chips in my teeth:  Would like to repair chips in my teeth:  Would like to repair chips in my teeth:  Wo	NAME  THE RESERVE OF THE PROPERTY OF THE PROPE	DATE
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The state of the s	The state of the s	
	Are your teeth sensitive to sweets, hot/cold, or biting pressure?	Oyes O No *

Holp us understand what also your deatist should be sur-	
Help us understand what else your dentist should know:	
YOUR MEDICAL HISTORY	
Are you in good health?	○Yes ○No *
Has there been any change in your general health?	○Yes ○No *
My last physical exam was:	*
Have you had a serious illness or operation?	○Yes ○No *
Have you had surgery or x-ray treatment for a tumor, growth or other condition of the mouth or lips?	Oyes O No *
Are you now under the care of a physician?	OYes ONo *
Have you ever required a blood transfusion?	○Yes ○No *
Have you been hospitalized or had serious illness within the past five (5) years?	○Yes ○No *
Have you had any serious problems associated with previous dental treatment?	Oyes Ono *
Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?	○Yes ○No *
Do you have any implants and/or Prothesis (i.e. hip replacements, knee joints, elbow pins, etc.)?	○Yes ○No *
Do you smoke or use tobacco products?	○Yes ○No *
Are you thirsty much of the time?	O
Does your mouth frequently become dry?	○Yes ○No *
Does your jaw pop or click when opening or chewing?	OYes ONo *
Has your jaw ever been stuck open or closed?	○Yes ○No *
GENDER SPECIFIC QUESTIONS	
DEROUGH STEELITE GOLDTIONS	
Are you pregnant or could you be?	Oyes Ono *
Are you nursing?	
Oral contraceptives?	OYes ONo *
SPECIALIST SPECIFIC QUESTIONS	
Height:	ft: *
Weight:	lbs *
Have your wisdom teeth been extracted?	OYes ONo *
When were they extracted:	*
Do you have Porphyria (blood disorder)?	OYes ONo *
Have you or anyone else in your family had malignant hyperthermia or other complications while under general anesthesia?	OYes ONo *
Do you have habits such as nail biting, pencil biting, or lip biting?	OYes ONo *
Do you have habits such as thumb sucking or mouth breathing?	OYes ○No *
Do you clench or grind your teeth?	OYes ONo *

Antibiotics or sulfa drugs?			
Aspirin?			
Insulin, tolbutamide (Orinase), or similar drug?			
Anticoagulants (blood thinners)?			
Medicine for high blood pressure?			
Cortisone (steroids)?			
Digitalis or drugs for heart trouble?			
Nitroglycerin?			-
Tranquilizers?			
Fen-Phen (now, or in the past) or any related drugs such as Ionimin, Adipex, Phentermine, Fastin, Pondimin (Fenfluramin), and Redux (dexfenfluramine)?			e Austrian sakinga na khannaseppe
Osteoporosis, chemotherapy or multiple myeloma medications (Bisphosphonates) such as Actonol, Boniva, Fosomax, Skelid and Bonefos? Hormone therapy/replacement?			
Hormone therapy/replacement?			and the same of th
Recreational or non-prescribed drugs?			 organização de la compansión de la compa
Other?	and the second of the second o		
OYes ONo (ex. Heart attack, Heart murmur and Stroke) *			
DYes ONo (ex. Heart attack, Heart murmur and Stroke) *	*		
HEART  DYes ONo (ex. Heart attack, Heart murmur and Stroke) * lease select all that apply  Heart transplant?			
HEART  OYes ONo (ex. Heart attack, Heart murmur and Stroke) *  lease select all that apply			
PYES ONO (ex. Heart attack, Heart murmur and Stroke) * lease select all that apply Heart transplant? Cardiovascular disease (heart trouble, heart attack, coronary			
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PYES ONO (ex. Heart attack, Heart murmur and Stroke) * lease select all that apply  Heart transplant?  Cardiovascular disease (heart trouble, heart attack, coronary occlusion, high blood pressure, arteriosclerosis, stroke)?  Congestive Heart failure?			
HEART  DYes ONo (ex. Heart attack, Heart murmur and Stroke) * lease select all that apply  Heart transplant?  Cardiovascular disease (heart trouble, heart attack, coronary occlusion, high blood pressure, arteriosclerosis, stroke)?  Congestive Heart failure?  Myocardial infarction?			
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ease select all that apply	
	П
Emphysema?	
Tuberculosis?	
Asthma?	Π
Bronchitis?	П
Hay fever? Chronic cough?	П
Difficults becathing	
Other?	
otter;	****
LIVER	,
Yes ONo (ex. Hepatitis) *	
ease select all that apply	
	П
Hepatitis A (infectious)?	П
Hepatitis B (serum)?	
Hepatitis C?	🖸
Jaundice or Liver disease?	
Other?	
KIDNEY	
OYes ○No (ex. Dialysis) *	
lease select all that apply	
Kidney transplant?	
Dialysis treatment?	
Frequent urination?	
Other?	
GASTROINTESTIONAL	
☐ Yes ☐ No (ex. Ulcers, Reflux and Gastric Bypass) *	
lease select all that apply	
Ulcers?	Ц
Diverticulitis? Bowel problems?	

Reflux/Heartburn GERD?  Eating Disorder?		
Other?		
BLOOD/ENDOCRINE		
OYes ONo (ex. AIDS, Anemia and Diabetes) *		
Please select all that apply		
AIDS or HIV+?	П	
Hemophilia?		
Sickle Cell disease?		
Diahetes?	П	
Hypoglycemia?		
Anemia?		
Thyroid?		
Sexually transmitted diseases?		
Other?		
MENTAL HEALTH/NERVOUS DISORDERS		
♥Yes ♥No (ex. Epilepsy, Anxiety and ADHD/ADD) *		
②Yes ○No (ex. Epilepsy, Anxiety and ADHD/ADD) *		
②Yes ○No (ex. Epilepsy, Anxiety and ADHD/ADD) *  Please select all that apply  Depression?  Output  Description:  Description:  Description:  Output  Description:  Description:  Description:  Output  Description:  Descri		
Yes ONo (ex. Epilepsy, Anxiety and ADHD/ADD) * Please select all that apply  Depression?  Sleep disorder?		
Yes ONo (ex. Epilepsy, Anxiety and ADHD/ADD) * Please select all that apply Depression? Sleep disorder? Epilepsy/Seizures? Fibromyalgia?		
○Yes ○No (ex. Epilepsy, Anxiety and ADHD/ADD) * Please select all that apply Depression? Sleep disorder? Epilepsy/Seizures?		
Yes ONo (ex. Epilepsy, Anxiety and ADHD/ADD) * Please select all that apply  Depression?  Sleep disorder?  Epilepsy/Seizures?  Fibromyalgia?  Mental Health problems?		
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Yes ONo (ex. Epilepsy, Anxiety and ADHD/ADD) * Please select all that apply  Depression? Sleep disorder? Epilepsy/Seizures? Fibromyalgia? Mental Health problems? Schizophrenia? Anxiety? Bi-polar? Autism?		
Yes ONo (ex. Epilepsy, Anxiety and ADHD/ADD) * Please select all that apply  Depression?  Sleep disorder?  Epilepsy/Seizures?  Fibromyalgia?  Mental Health problems?  Schizophrenia?  Anxiety?  Bi-polar?  Autism?  ADHD/ADD Attention Deficit?		
Yes ONo (ex. Epilepsy, Anxiety and ADHD/ADD) * Please select all that apply  Depression?  Sleep disorder?  Epilepsy/Seizures?  Fibromyalgia?  Mental Health problems?  Schizophrenia?  Anxiety?  Bi-polar?  Autism?  ADHD/ADD Attention Deficit?  Other?		
Yes ONo (ex. Epilepsy, Anxiety and ADHD/ADD) * Please select all that apply  Depression?  Sleep disorder?  Epilepsy/Seizures?  Fibromyalgia?  Mental Health problems?  Schizophrenia?  Anxiety?  Bi-polar?  Autism?  ADHD/ADD Attention Deficit?  Other?		
Yes ONo (ex. Epilepsy, Anxiety and ADHD/ADD) * Please select all that apply  Depression? Sleep disorder? Epilepsy/Seizures? Fibromyalgia? Mental Health problems? Schizophrenia? Anxiety? Bi-polar? Autism? ADHD/ADD Attention Deficit? Other?		
②Yes ○No (ex. Epilepsy, Anxiety and ADHD/ADD) * Please select all that apply  Depression?  Sleep disorder?  Epilepsy/Seizures?  Fibromyalgia?  Mental Health problems?  Schizophrenia?  Anxiety?  Bi-polar?  Autism?  ADHD/ADD Attention Deficit?  Other?  OTHER  OYes ○ No (ex. Cancer, Chemotherapy and Arthritis)	*	

Cold sores?  Radiation therapy?		
\$ 1.00 miles   1.0		
Chemotherapy?		
Severe headaches/Migraines??		
Delayed healing?		
Contact lenses?		
Chronic fatigue?		
Inflammatory rheumatism (painful, swollen joints)	)?	
Arthritis?		
Other?		
		etropia yan sandatajiri, sa serinci sa na denggajiri in
ALLERGIES		
		THE PARTY OF THE P
oo you have any allergies or have you reacted adv n the past?	ersely to anything  Oyes  O No *	
lease select all that apply	Jies O No	
Local anesthetic?	E1	
Aspirin?	<u> </u>	
Penicillin or other antibiotics	Ц	
Codeine or other parcotics?	<u>U</u>	
Iodine?	P-1	
Commence of the commence of th	<u>.</u> <u>L</u>	
Barbiturates, sedatives, or sleeping pills?		
time Visiting the Commence of	<u>L</u>	
Hives or skin rash? Sulfa drugs?	<u> </u>	
Asthma or hay fever?		
Eags?	<u> </u>	
Eggs?	<u>.</u> <u>.</u>	
Soybean?		
Other?	**************************************	
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ertify that the above information is correct to the	best of my knowledge. I understand	that provid
formation can be dangerous to my health and I wil	ll not hold my Dentist or any member	rs of his/he
sponsible for errors or emissions that I have made	in completion of this form. It is my re	esponsibil
entist of any changes in the above medical status.	54 W. (5)	
tient or Responsible Party Signature: X		ate: