

# DENTAL HEALTH HISTORY

**Please mark any that apply:**

- |   |  |
|---|--|
| Are you apprehensive about dental treatment?          | Y N<br><input type="checkbox"/> <input type="checkbox"/> |
| Have you had problems with previous dental treatment? | <input type="checkbox"/> <input type="checkbox"/>        |
| Do you gag easily?                                    | <input type="checkbox"/> <input type="checkbox"/>        |
| Do your gums bleed when you brush or floss?           | <input type="checkbox"/> <input type="checkbox"/>        |
| How often do you brush? _____                         | <input type="checkbox"/> <input type="checkbox"/>        |
| How often do you floss? _____                         | <input type="checkbox"/> <input type="checkbox"/>        |
| Do you clench or grind your jaws frequently?          | <input type="checkbox"/> <input type="checkbox"/>        |

- |   |  |
|---|--|
| Do you feel twinges of pain when your teeth come in contact with: | Y N<br><input type="checkbox"/> <input type="checkbox"/> |
| Hot foods or liquids?   | <input type="checkbox"/> <input type="checkbox"/>        |
| Cold foods or liquids?  | <input type="checkbox"/> <input type="checkbox"/>        |
| Sours?  | <input type="checkbox"/> <input type="checkbox"/>        |
| Sweets?   | <input type="checkbox"/> <input type="checkbox"/>        |

# MEDICAL HEALTH HISTORY

**Do you have, or have you had, any of the following:**

- |                           |  |   |  |  |  |
|---------------------------|--|---|--|--|--|
| <b>Heart Problems</b>     | Y N<br><input type="checkbox"/> <input type="checkbox"/> | <b>Intestinal Problems</b>                  | Y N<br><input type="checkbox"/> <input type="checkbox"/> | <b>Diabetes</b>  | Y N<br><input type="checkbox"/> <input type="checkbox"/> |
| Chest pain                | <input type="checkbox"/> <input type="checkbox"/>        | Ulcers                                      | <input type="checkbox"/> <input type="checkbox"/>        | Urinate more than 6 times a day  | <input type="checkbox"/> <input type="checkbox"/>        |
| Shortness of breath       | <input type="checkbox"/> <input type="checkbox"/>        | Weight gain or loss                         | <input type="checkbox"/> <input type="checkbox"/>        | Thirsty or mouth is dry much of the time   | <input type="checkbox"/> <input type="checkbox"/>        |
| Blood pressure problem    | <input type="checkbox"/> <input type="checkbox"/>        | Kidney or bladder problems                  | <input type="checkbox"/> <input type="checkbox"/>        | Family history of diabetes   | <input type="checkbox"/> <input type="checkbox"/>        |
| Heart murmur              | <input type="checkbox"/> <input type="checkbox"/>        | <b>Bone or Joint Problems</b>               | <input type="checkbox"/> <input type="checkbox"/>        | Hepatitis, jaundice, or liver trouble  | <input type="checkbox"/> <input type="checkbox"/>        |
| Heart valve problem       | <input type="checkbox"/> <input type="checkbox"/>        | Arthritis                                   | <input type="checkbox"/> <input type="checkbox"/>        | Herpes or other STD  | <input type="checkbox"/> <input type="checkbox"/>        |
| Taking heart medication   | <input type="checkbox"/> <input type="checkbox"/>        | Back or neck pain                           | <input type="checkbox"/> <input type="checkbox"/>        | HIV-positive/AIDS  | <input type="checkbox"/> <input type="checkbox"/>        |
| Rheumatic fever           | <input type="checkbox"/> <input type="checkbox"/>        | Joint replacement                           | <input type="checkbox"/> <input type="checkbox"/>        | Glaucoma   | <input type="checkbox"/> <input type="checkbox"/>        |
| Pacemaker                 | <input type="checkbox"/> <input type="checkbox"/>        | (e.g. total hip, pins, or implants)         |  | Do you wear contact lenses?  | <input type="checkbox"/> <input type="checkbox"/>        |
| Artificial heart valve    | <input type="checkbox"/> <input type="checkbox"/>        | Fainting Spells, Seizures, or Epilepsy      | <input type="checkbox"/> <input type="checkbox"/>        | History of head injury?  | <input type="checkbox"/> <input type="checkbox"/>        |
| <b>Blood Problems</b>     | <input type="checkbox"/> <input type="checkbox"/>        | Stroke(s)                                   | <input type="checkbox"/> <input type="checkbox"/>        | Epilepsy or other neurological disease?  | <input type="checkbox"/> <input type="checkbox"/>        |
| Abnormal bleeding         | <input type="checkbox"/> <input type="checkbox"/>        | Frequent or severe headaches                | <input type="checkbox"/> <input type="checkbox"/>        | History of alcohol or drug abuse?  | <input type="checkbox"/> <input type="checkbox"/>        |
| Blood disease (anemia)    | <input type="checkbox"/> <input type="checkbox"/>        | Thyroid problems                            | <input type="checkbox"/> <input type="checkbox"/>        | Do you have any disease, condition, or problem not listed previously that you feel we should know about? | <input type="checkbox"/> <input type="checkbox"/>        |
| <b>Allergy Problems</b>   | <input type="checkbox"/> <input type="checkbox"/>        | Persistent cough or swollen glands          | <input type="checkbox"/> <input type="checkbox"/>        | If so, please describe _____   |  |
| Hay fever                 | <input type="checkbox"/> <input type="checkbox"/>        | <b>Premedications required by physician</b> | <input type="checkbox"/> <input type="checkbox"/>        |  |  |
| Sinus problems            | <input type="checkbox"/> <input type="checkbox"/>        | Cancer/Tumor                                | <input type="checkbox"/> <input type="checkbox"/>        |  |  |
| Skin rashes               | <input type="checkbox"/> <input type="checkbox"/>        | Tuberculosis or other respiratory disease   | <input type="checkbox"/> <input type="checkbox"/>        |  |  |
| Taking allergy medication | <input type="checkbox"/> <input type="checkbox"/>        | Do you smoke?                               |  |  |  |
| Asthma                    | <input type="checkbox"/> <input type="checkbox"/>        | If so, how much? _____                      |  |  |  |

**During the past 12 months, have you taken any of the following?**

- |                                      |  |
|--------------------------------------|--|
| Antibiotics or sulfa drugs           | Y N<br><input type="checkbox"/> <input type="checkbox"/> |
| Anticoagulants (e.g., Coumadin)      | <input type="checkbox"/> <input type="checkbox"/>        |
| High blood pressure medicine         | <input type="checkbox"/> <input type="checkbox"/>        |
| Osteoporosis medication              | <input type="checkbox"/> <input type="checkbox"/>        |
| Tranquilizers                        | <input type="checkbox"/> <input type="checkbox"/>        |
| Insulin, Orinase, or similar drug    | <input type="checkbox"/> <input type="checkbox"/>        |
| Aspirin                              | <input type="checkbox"/> <input type="checkbox"/>        |
| Digitalis or drugs for heart trouble | <input type="checkbox"/> <input type="checkbox"/>        |
| Nitroglycerin                        | <input type="checkbox"/> <input type="checkbox"/>        |
| Cortisone (steroids)                 | <input type="checkbox"/> <input type="checkbox"/>        |
| Natural remedies                     | <input type="checkbox"/> <input type="checkbox"/>        |
| Nonprescription drug/supplements     | <input type="checkbox"/> <input type="checkbox"/>        |
| Other _____                          |  |

**Are you allergic, or have you reacted adversely, to any of the following?**

- |  |  |
|--|--|
| Local anesthetics ("Novocaine")            | Y N<br><input type="checkbox"/> <input type="checkbox"/> |
| Penicillin or other antibiotics            | <input type="checkbox"/> <input type="checkbox"/>        |
| Sulfa drugs                                | <input type="checkbox"/> <input type="checkbox"/>        |
| Barbiturates, sedatives, or sleeping pills | <input type="checkbox"/> <input type="checkbox"/>        |
| Aspirin, Acetaminophen, or Ibuprofen       | <input type="checkbox"/> <input type="checkbox"/>        |
| Codeine, Demerol, or other narcotics       | <input type="checkbox"/> <input type="checkbox"/>        |
| Reaction to metals                         | <input type="checkbox"/> <input type="checkbox"/>        |
| Latex or rubber dam                        | <input type="checkbox"/> <input type="checkbox"/>        |
| Other _____                                |  |
| Notes: _____                               |  |

**Women**

- |  |  |
|--|--|
| Are you taking contraceptives or other hormones?       | Y N<br><input type="checkbox"/> <input type="checkbox"/> |
| Are you pregnant? If so, expected delivery date: _____ | <input type="checkbox"/> <input type="checkbox"/>        |
| Are you nursing?                                       | <input type="checkbox"/> <input type="checkbox"/>        |
| Notes: _____   |  |

**Current list of medications:**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize Dr. Paul McGriff and/or dental staff to perform all necessary dental services that I may need.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Notes:** \_\_\_\_\_

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