THE CENTRE FOR
Contemporary Dentistry

Health History

PATIENT INFORMATION	
Full Name:	
Preferred Name:	Date of Birth: / /

DENTAL HISTORY & SYMPTOMS		
What is the reason for your visit today?		
Are you currently experiencing any dental pain or discomfort?	☐ Yes	☐ No
If yes, where?		
When was your last dental exam?		
When was the last time you had dental x-rays taken?		
What office were the x-rays taken at?		
Does dental treatment make you nervous?	☐ Yes	☐ No
Have you ever had periodontal (gum) treatments like scaling or root planing?	☐ Yes	☐ No
Has a doctor or dentist said that you need to take **antibiotics** before having dental work?	☐ Yes	☐ No

ALLERGIES		
Are you allergic to or have you ever had an allergic reaction to:	**Yes**	**No**
Penicillin or other antibiotics – Please list:	☐	☐
Latex (rubber)	☐	☐
Local Anesthetics – Please list if known:	☐	☐
Aspirin	☐	☐
Barbiturates, sedatives, or sleeping pills – Please list:	☐	☐
Codeine or other narcotics – Please list:	☐	☐
Hayfever/seasonal allergies	☐	☐
Sulfa drugs	☐	☐
Other – Please list:	☐	☐

MEDICATIONS & SUBSTANCES				
	Yes	**No**	**If yes, please list:**	
Are you taking any **blood thinners**?	☐	☐		
Are you on any medications for **osteoporosis**?	☐	☐		
Are you taking any types of **steroids**?	☐	☐		
Are you taking any **IV medications** or **injections**?	☐	☐		
Do you consume **alcohol**?	☐	☐	Frequency:	
Do you use any form of **tobacco** or **nicotine**?	☐	☐	Type:	Frequency:
Do you use any **recreational drugs**?	☐	☐	Type:	Frequency:
Do you take any other medications or supplements?	☐	☐		

MEDICAL & SURGICAL HISTORY

Date of last physical exam:

Physician's Name: Phone:

Have you had a serious illness, operation, or been hospitalized in the last 5 years? ☐ Yes ☐ No

If so, what was it for?

Do you have, or have you been diagnosed with, any of the following conditions?

	Yes	No		Yes	No		Yes	No
CARDIAC			**CANCER**			**CIRCULATORY**		
Heart valve surgery	☐	☐	Type:	☐	☐	Anemia	☐	☐
Pacemaker/defibrillator	☐	☐	Diagnosis date:			Blood transfusions	☐	☐
Artificial heart valve	☐	☐	Chemotherapy:			Hemophilia	☐	☐
Congenital heart disease	☐	☐	Radiation Treatment:			High or low blood pressure	☐	☐
Coronary artery disease	☐	☐	**DIGESTIVE**			**OTHER**		
Arteriosclerosis	☐	☐	Stomach ulcers	☐	☐	Diabetes (I or II)	☐	☐
Congestive heart failure	☐	☐	Gastrointestinal disease	☐	☐	Arthritis	☐	☐
Heart attack	☐	☐	GERD	☐	☐	Herpes	☐	☐
Heart murmur	☐	☐	**NEUROLOGICAL & MENTAL**			Hepatitis	☐	☐
Stroke	☐	☐	Epilepsy	☐	☐	Kidney problems	☐	☐
RESPIRATORY			Mental health disorders	☐	☐	Thyroid disorder	☐	☐
Asthma	☐	☐	**AUTOIMMUNE**			Osteoporosis	☐	☐
COPD	☐	☐	HIV or AIDS	☐	☐	Joint replacement	☐	☐
Emphysema	☐	☐	Lupus	☐	☐	Please specify: _____		
Tuberculosis	☐	☐	**VISION**			Organ Transplant	☐	☐
Sinus problems	☐	☐	Glaucoma	☐	☐	Please specify: _____		

If you have a condition not listed here, please explain: _____

WOMEN ONLY:

Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant and/or nursing? ☐ Yes ☐ No Number of weeks:

I have answered the above questions completely, accurately, and to the best of my ability.

Signature: _____	Date: / /
Signature: _____	Date: / /
Signature: _____	Date: / /
Signature: _____	Date: / /
Signature: _____	Date: / /
Signature: _____	Date: / /