HEALTH HISTORY FORM

Date _____ Name _____

Home Phone (___)_____ Cell (___)_____ Work (___)_____

Street Address _____ City _____ State _____ Zip Code _____

Mailing Address (if different than above):

Street Address _____ City _____ State _____ Zip Code _____

Date of Birth _____ Sex M F Occupation _____ Preferred Pharmacy:_____

Emergency Contact Name: _____Phone Number: _____ Relationship _____

If you are completing this form for another person, what is your relationship to this person? _____

Signature of Responsible Party: _____

DENTAL INFORMATION

YES	NO	UNKNOWN		YES	NO	UNKNOWN	
☐	☐	☐	Do your gums bleed when you brush?	☐	☐	☐	Do you frequently get blisters on lips or mouth?
☐	☐	☐	Have you ever had orthodontic treatment?	☐	☐	☐	Do you have a family history of periodontal disease?
☐	☐	☐	Are your teeth sensitive to cold, hot, sweets, or pressure?	☐	☐	☐	Do you ever get a burning sensation on tongue?
☐	☐	☐	Do you have headaches, earaches or neck pains?	☐	☐	☐	Do you chew on one side of mouth?
☐	☐	☐	Have you had any periodontal (gum) treatments?	☐	☐	☐	Do you get clicking or popping of your jaw?
☐	☐	☐	Do you wear removable/fixed dental appliances?	☐	☐	☐	Do you bite your nails or foreign objects?
☐	☐	☐	Have you been told you have periodontal (gum) disease?	☐	☐	☐	Do you get jaw pain or tiredness?
☐	☐	☐	Are you aware of loose teeth or broken fillings?	☐	☐	☐	Does food collect between your teeth?
☐	☐	☐	Are your gums swollen or tender?	☐	☐	☐	Do you have pain when brushing?
☐	☐	☐	Are you a mouth breather?	☐	☐	☐	Do you or have you been told you grind your teeth?
☐	☐	☐	Have you had any problems associated with previous dental treatment or past dental experiences? If so explain: _____				

Oral habits (Circle all that apply)

Tongue/lip piercing Ice chewing Musical instrument with mouthpiece Using teeth as a tool

What fluoride products do you use/consume? (Circle all that apply) Toothpaste Water Rinses Other _____

What are the three most important factors you desire from your dental office?

1. _____ 2. _____ 3. _____

How do you feel about the appearance of your teeth? _____

Do you have any problems with bad breath? _____

How often do you floss? _____/day

How often do you brush? _____/day

How often do you have dental check ups? _____

Please indicate the level of dental care you would like us to provide:

☐ Emergency care as needed

☐ Consultation to solve a specific problem

☐ Routine exam and preventive care

☐ Comprehensive care, optimal dental health and appearance