Blasek Family Dentistry

Health History Form

Name: **Today's Date:**

Are you now under the care of a physician? ☐ YES ☐ NO Physician Name Phone Number

Dental Information

1. Do your gums bleed when you brush or floss? ☐ YES ☐ NO
2. Are your teeth sensitive to cold, hot, sweets or pressure? ☐ YES ☐ NO
3. Is your mouth dry? ☐ YES ☐ NO
4. Have you ever had orthodontic (braces) treatment? ☐ YES ☐ NO
5. Have you had any problems associated with previous dental treatment? ☐ YES ☐ NO
6. Are you currently experiencing dental pain or discomfort? ☐ YES ☐ NO
7. Do you have earaches or neck pains? ☐ YES ☐ NO
8. Do you have any clicking, popping or discomfort in the jaw? ☐ YES ☐ NO
9. Do you grind your teeth? ☐ YES NO
10. Do you have sores or ulcers in your mouth? ☐ YES ☐ NO
11. Do you wear dentures or partials? ☐ YES ☐ NO
12. Have you ever had a serious injury to your head or mouth? ☐ YES ☐ NO
13. Date of your last dental exam: _____
14. What was done at that time?
15. Date of last dental x-rays: _____

Please list any medications, pills or drugs

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Medical Information

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Please list any other allergies

- Do you use tobacco? ☐ YES ☐ NO
- Do you use controlled substances? ☐ YES ☐ NO
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ YES ☐ NO If yes, please list

Women Only: Are you...

☐ Pregnant ☐ Trying to get pregnant ☐ Nursing ☐ Tasking Oral contraceptives

Please indicate if you have any of the following

☐ Acid Reflux	☐ HIV +/AIDS	☐ Alzheimer's Disease	☐ Anaphlaxis	☐ Anemia
☐ Angina/ Chest Pain	☐ Arthritis/ Rheumatism	☐ Artificial Heart Valve	☐ Artificial Joint	☐ Asthma
☐ Blood Disease	☐ Blood Transfusion	☐ Bruise Easily	☐ Cancer IF YES, WHAT KIND?	☐ Chemotherapy
☐ Congenital Heart Disorder	☐ Convulsions	☐ COPD/ Lung Disease	☐ Diabetes (Type I/ Type II) PLEASE CIRCLE	☐ Drug Addiction
☐ Emphysema	☐ Epilepsy or Seizures	☐ Fainting Spells/ Dizziness	☐ Frequent Cough	☐ Frequent Headaches
☐ Glaucoma	☐ Heart attack/ Failure	☐ Heart Murmer	☐ Heart Pace Maker	☐ Heart Disease
☐ Hemophilia	☐ Hepatitis A/B/C PLEASE CIRCLE	☐ Herpes Type I/ Type II	☐ High Blood Pressure	☐ High Cholesterol
☐ Hives or Rash	☐ Hypoglycemia	☐ Kidney Problems	☐ Osteoporosis	☐ Parathyroid Disease
☐ Psychiatric Care	☐ Sickle Cell Disease	☐ Sinus Trouble	☐ Shingles	☐ Stroke
☐ Gout	☐ Sleep Apnea	☐ Tonsillitis	☐ Tuberculosis	☐ Taking- Anti-Coagulant
☐ Thyroid Disease	☐ Tumors or Growths	☐ Ulcers	☐ Venereal Disease	☐ Autoimmune Disease IF YES, WHAT KIND?

Have you ever had any serious illness not listed above?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature: _____ **Date:** _____