PARKSIDE FAMILY DENTISTRY
COMPREHENSIVE FAMILY & COSMETIC DENTISTRY

Health History

DENTAL HEALTH HISTORY

Patient First Name ____ Patient Last Name ____ DOB ____ Today's Date ____

How do you feel about dental treatment? ☐ Relaxed ☐ A little uneasy ☐ Tense ☐ Anxious ☐ Very Anxious ☐ Major Phobia

Reason for seeking dental care at this time? ____

Are there any other concerns or interests you have about your dental health that you would like the Doctor to address during your visit? ____

How often do you brush & floss? Brush ☐1 ☐2 ☐3+ per ☐Day ☐Week ☐Month ☐Never Floss ☐1 ☐2 ☐3+ per ☐Day ☐Week ☐Month ☐Never

Date of last dental visit?____ Date of last dental x-rays?____ Previous Dentist____

Why did you leave your previous dentist? ____

Have you ever whitened your teeth? ☐Yes ☐No Are you interested in whitening your teeth? ☐Yes ☐No ☐Maybe

Please check the following that you've had or currently do have: ☐ Fixed Bridge ☐ Partial Denture ☐ Denture ☐ Dental Implants ☐ Veneers ☐ Gum Surgery ☐ Orthodontics (braces) ☐ Jaw Surgery ☐ Root Canal ☐ ____

Please check all that apply:

☐ Hot/Cold sensitive teeth
☐ Teeth sensitive to sweets
☐ Sore/Bleeding gums
☐ Periodontal disease
☐ Missing teeth
☐ Toothaches
☐ Offensive/Bad Breath
☐ Consume Coffee/Tea
☐ Sensitive to metals
☐ Unfavorable dental experience
☐ Grinding/Clenching of teeth
☐ Face/Mouth pain
☐ Clicking/Popping of jaw
☐ Difficulty Opening/Chewing
☐ Unsightly Spaced teeth
☐ Crooked/Tipped teeth
☐ Growth or lesion in your mouth
☐ Swollen glands
☐ Broken filling(s)
☐ Does jaw pain affect daily routine
☐ Cold Sores/Oral Lesions
☐ Catch food between teeth
☐ Discolored teeth
☐ Loose teeth
☐ Chipped or broken teeth
☐ Gag easily
☐ Wear dentures or partials
☐ Is your bite uncomfortable or uneven
☐ Dissatisfied with appearance of your teeth
☐ Do you prefer to save your teeth

If you could change something about the look or feel of your smile/teeth, what would it be?

☐ Make them whiter
☐ Make them straighter
☐ Replace missing teeth
☐ Replace old crowns that don't match
☐ Have a smile makeover
☐ Replace black fillings that don't look natural
☐ Repair chipped teeth
☐ Other ____

On a scale of 1 – 10, with 10 being the highest rating:

How important is your dental health to you? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Where would you rate your current dental health? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

NOTES: ____

Signature ____ **Printed Name** ____ **Relationship to Patient** ____

Revised 09/12

PARKSIDE FAMILY DENTISTRY
COMPREHENSIVE FAMILY & COSMETIC DENTISTRY

Health History

MEDICAL HEALTH HISTORY

Patient First Name ______ Patient Last Name ______ DOB ______ Today's Date ______

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Please answer the following. If yes, please explain. Use back of paper or attach list if needed:

Are you under a physician's care now? ☐Yes ☐No ______

Have you ever been hospitalized or had a major operation? ☐Yes ☐No ______

Have you ever had a serious head or neck injury? ☐Yes ☐No ______

Are you taking any medications, pills, or drugs? ☐Yes ☐No ______

Do you take, or have you taken, Phen-Fen or Redux? ☐Yes ☐No ______

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? ☐Yes ☐No

Are you on a special diet? ☐Yes ☐No

Women: Are you
Pregnant/Trying to get pregnant? ☐Yes ☐No Taking oral contraceptives? ☐Yes ☐No Nursing? ☐Yes ☐No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Erythromycin ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthesia ☐ Sulfa Drugs

☐ Other If yes, please explain ______

Do you have, or have you had, any of the following?

☐AIDS/HIV	☐Chest Pains	☐Fainting Spells/Dizziness	☐Hives or Rash	☐Scarlet Fever
☐Alzheimer's Disease	☐Cold Sores/Fever Blisters	☐Frequent Cough	☐Hypoglycemia	☐Shingles
☐Anaphylaxis	☐Congenital Heart Disorder	☐Frequent Diarrhea	☐Irregular Heartbeat	☐Sickle Cell Disease
☐Anemia	☐Convulsions	☐Frequent Headaches	☐Kidney Problems	☐Sinus Trouble
☐Angina	☐Cortisone Medicine	☐Frequent Nosebleeds	☐Leukemia	☐Slow Clotting
☐Arthritis/Gout	☐Diabetes	☐Glaucoma	☐Liver Disease	☐Spina Bifida
☐Artificial Heart Valve	☐Family history of Diabetes	☐Hay Fever	☐Low Blood Pressure	☐Stomach/Intestinal Disease
☐Artificial Joint	☐Do you drink alcohol?	☐Heart Attack/Failure	☐Lung Disease	☐Stroke
☐Asthma	☐Do you smoke?	☐Heart Murmur	☐Mitral Valve Prolapse	☐Swelling of Limbs
☐Back/Neck Pain	☐Do you use recreational drugs?	☐Heart Pace Maker	☐Pain in Jaw Joints	☐Thyroid Disease
☐Blood Disease	☐Drug Addiction	☐Heart Trouble/Disease	☐Parathyroid Disease	☐Tonsillitis
☐Blood Transfusion	☐Easily Winded	☐Hemophilia	☐Radiation Treatments	☐Tuberculosis
☐Breathing Problem	☐Emphysema	☐Hepatitis A	☐Recent Weight Loss	☐Tumors or Growths
☐Bruise Easily	☐Epilepsy or Seizures	☐Hepatitis B or C	☐Renal Dialysis	☐Ulcers
☐Cancer	☐Excessive Bleeding	☐Herpes	☐Rheumatic Fever	☐Venereal Disease
☐Chemotherapy	☐Excessive Thirst/Dry	☐High Blood Pressure	☐Rheumatism	☐Yellow Jaundice

Comments: ______

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 ______ **Printed Name** ______ **Relationship to Patient** ______

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