Grace Health

Dental Health History

Patient's Name _____ Birth Date _____ Today's Date _____

Please circle the correct response (Yes or No); answer all questions. If you are not sure, just go to the next question. The following questions are for our records only and will be considered confidential information.

Dental History

Why are you seeing the dentist today? _____

1. Have you ever had any problems after dental extractions or treatment? ... Yes No
2. Have you ever had a bad or unusual reaction to a local or general dental anesthetic? ... Yes No
3. Have you ever had an injury to your face, teeth, jaws? ... Yes No
4. Have you ever had surgery in/on your mouth or lips? ... Yes No
5. Have you ever had radiation treatment of your neck or head? ... Yes No
6. Have you ever had any teeth pulled? ... Yes No
7. Do you have bleeding gums? ... Yes No
8. Do you ever have sores in your mouth? ... Yes No
9. Do you have trouble chewing? ... Yes No
10. Do you clench or grind your teeth? ... Yes No
11. Do you have trouble opening your mouth as wide as you would like? ... Yes No
12. Do your jaw joints, jaw muscles or neck hurt often? ... Yes No
13. Does your jaw ever lock, click or pop? ... Yes No
14. Are you wearing any removable dental appliances? ... Yes No
    If Yes, for how many years? _____
    For how many years have you been without your permanent teeth? _____
    If you have dentures and you are not wearing them, for how long have you not been wearing them? _____

Medical History

1. Are you in good health? ... Yes No
2. Have there been changes in your general health in the past year? ... Yes No

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

3. Heart problems such as heart attack, chest pain, irregular heart beat, artificial heart valve, previous endocarditis, damaged (scarred) heart valves, congenital heart defects, heart transplant? ... Yes No
4. Pacemaker, defibrillator or other cardiac device? ... Yes No
5. Shortness of breath or chest pain with mild exercise? ... Yes No
6. High or low blood pressure? ... Yes No
7. Stroke or mini-stroke (TIA)? ... Yes No
8. Blood disorders such as anemia, hemophilia, clotting disorder? ... Yes No
9. Lung problems such as tuberculosis, emphysema, bronchitis, COPD? ... Yes No
10. Sinus trouble, hay fever, asthma? ... Yes No
11. Any reactions to drugs or other types of allergies? ... Yes No
    If Yes, please list _____
12. History of bisphosphonate medications (intravenous - - Zometa, Aredia, Reclast, or Bonefos, or oral medications - - Actonel, Boniva, Fosamax, Fosamax Plus D, Skelid or Didronel?) ... Yes No
13. Allergy to latex or rubber products? ... Yes No
14. Hives or skin rash? ... Yes No
15. Any STDs (syphilis, gonorrhea, herpes or other)? ... Yes No
16. AIDS or other immunosuppressive disorder or positive HIV test? ... Yes No
17. Hepatitis, jaundice or liver disease? ... Yes No
18. Diabetes (high blood sugar) or low blood sugar? ... Yes No
19. Kidney disease or dialysis? ... Yes No
20. Ulcers, stomach or intestinal problems? ... Yes No
21. Fainting spells, convulsions, seizures or epilepsy? ... Yes No

(over)

22. Emotional problems, depression or mental illness? ..... Yes No
23. Thyroid disease? ..... Yes No
24. Cancer, tumor, chemotherapy or radiation therapy? ..... Yes No
25. Arthritis or painful, swollen joints? ..... Yes No
26. A joint replacement (artificial joint)? ..... Yes No
27. An organ transplant? ..... Yes No
28. Frequent or severe headaches? ..... Yes No
29. Ear, nose or throat problems? ..... Yes No
30. Glaucoma or other eye problems? ..... Yes No

Please answer the following questions:

31. Are you pregnant? ..... Yes No
    If Yes, what is your due date? _____
32. Are you nursing? ..... Yes No
33. Have you had anything to eat or drink in the last 4 hours? ..... Yes No
34. Do you now or have you ever used tobacco products? ..... Yes No
35. If you currently use tobacco, are you interested in quitting? ..... Yes No
36. Have you ever been treated for drug or alcohol abuse? ..... Yes No
37. Have you been hospitalized, had major surgery or been seriously hurt? ..... Yes No
38. Are you currently under the care of a physician? ..... Yes No
    If Yes, for what condition(s)? _____
    Physician's name? _____
    Physician's address? _____
39. Are you taking any medications now or taken any recently? ..... Yes No
    If Yes, list **<u>any</u>** prescription/non-prescription medicine, herbal treatments or supplements, dose and how often:

Examiner's Comments:

I certify that, to the best of my knowledge, the above information is complete and accurate. I certify that my questions, if any, about any inquiries set forth above have been answered to my satisfaction.

Patient/Legal Guardian Signature _____ Date _____

Dentist Signature _____ Date _____

This history form should be updated at every visit. A new form should be filled out no less frequently than annually.