Today's Date_________

Patient's Name	Prefer to be called	Date of Birth	**OFFICIAL USE ONLY**
Physician's Name and Address			Pre-Med Yes No
Physician's Phone			Comments:
Date of your most recent visit to Physician	Reason		BP:
How would you assess your general Health?	Good Fair Poor		Pulse:

To ensure your well being while undergoing treatment in our office, please answer the following questions in detail. All information will be considered confidential and for our records only.

	Yes	No
1. Are you seeing a physician at the present time for the treatment of a recent or ongoing medical condition?	☐	☐
2. Have you been hospitalized within the last year? If yes, explain:	☐	☐
3. Have you had a serious illness or operation within the last year? If yes, explain:	☐	☐
4. Have you ever had any serious medical trouble associated with any dental experience? If yes, explain:	☐	☐
5. Have you ever been advised to take antibiotics (like penicillin, etc.,) before a dental appointment? If yes, explain:	☐	☐

Do you now or have you had any of the following diseases or problems?

	Yes	No
Cardiovascular Disease …………………	☐	☐

If yes, check any that apply:

- ☐ heart disease
- ☐ coronary bypass
- ☐ angina
- ☐ mitral valve prolapse
- ☐ high blood pressure
- ☐ hardening of the arteries
- ☐ stroke
- ☐ heart murmur
- ☐ congestive heart failure
- ☐ heart attack

	Yes	No
Rheumatic fever or rheumatic heart disease	☐	☐
Congenital heart defects	☐	☐
Prosthetic (artificial) heart valves	☐	☐
Pacemaker? If yes, date of placement _______________	☐	☐
High blood pressure	☐	☐
High cholesterol	☐	☐
Are you short of breath after mild exercise?	☐	☐
Do your ankles swell?	☐	☐
Do you get short of breath when you lie down?	☐	☐
Do you have chest pain upon exertion?	☐	☐
Abnormal bleeding or extended clotting time	☐	☐
Frequent or unexpected nose bleeds	☐	☐

Your normal blood pressure

_________/_________

HEALTH HISTORY

	Yes	No
Diabetes?	☐	☐
If yes, do you require insulin?	☐	☐
Type and Dose ________________________		
Do you have an artificial joint?	☐	☐
If yes, which joint(s)? __________________________		
Hepatitis?	☐	☐

If yes, check type:

☐ Type A ☐ Other
☐ Type B ☐ Non-Specific Type
☐ Type C ☐ Don't know

	Yes	No
Have you ever required a blood transfusion?	☐	☐
If yes, what was the date of the transfusion? _________________		
Are you HIV positive?	☐	☐
Do you have any reason to suspect that you have been exposed to the HIV virus	☐	☐
Have you ever had Tuberculosis (TB)?	☐	☐
Have you ever had a TB test?	☐	☐
Do you have a cough that has lasted more than 3 weeks?	☐	☐
Do you ever cough up blood?	☐	☐

CHECK ANY THAT APPLY:

☐ Allergies
☐ Alzheimer's Disease
☐ Anemia
☐ Angina
☐ Asthma
☐ Arthritis
☐ Autoimmune Disease
☐ Blood Disorder
☐ Cancer
☐ Chemo Therapy
☐ Chronic/ Recurring Sinus Problems
☐ Cirrhosis
☐ Depression
☐ Diabetes
☐ Drug or Alcohol Treatment
☐ Eating Disorder
☐ Epilepsy or Other Seizures
☐ Heart Disease
☐ Herpes
☐ Jaundice or Liver Disease
☐ Serious/Frequent Headaches
☐ Glaucoma
☐ HIV / AIDS
☐ Joint Replacement
☐ Kidney Disease
☐ Organ Transplant
☐ Osteoporosis
☐ Parkinson's Disease
☐ Radiation Treatment
☐ Respiratory Problems
☐ Sexually Transmitted Disease
☐ Skin Problems
☐ Tuberculosis
☐ Ulcers
☐ Other__________________

	Yes	No
Do you consider yourself currently under an abnormally high amount of stress?	☐	☐
Have you had any unexplained or unplanned weight loss recently?	☐	☐
Do you now or have you ever smoked?	☐	☐

(Please circle) Cigarettes Pipe Cigar Other
If you currently smoke, how much?_________
If you have smoked in the past but no longer smoke, when did you quit? ____________

	Yes	No
Do you chew tobacco?	☐	☐
If yes, how often? __________________		
Do you drink alcohol?	☐	☐
If yes, how much? __________________		

HEALTH HISTORY

If you are currently taking these medications, check the box on the left. If you have taken any of these medications within the past year, but are not taking them currently, check the box on the right.

Now	Past Year	
☐	☐	Antibiotics
☐	☐	Antidepressants (Prozac, Zoloft, etc.)
☐	☐	Antihistamines
☐	☐	Blood Pressure Medicine
☐	☐	Blood Thinners
☐	☐	Cortisone (Prednisone, etc.)
☐	☐	Cholesterol Medication
☐	☐	Decongestants
☐	☐	Diuretics (water pills)
☐	☐	Hormones (birth control pills, estrogen)
☐	☐	Inhalants
☐	☐	Insulin
☐	☐	Medicine for Heart Problems
☐	☐	Muscle Relaxants
☐	☐	Nitroglycerine
☐	☐	Pain Medicine (Aspirin, Advil, Tylenol, etc.)
☐	☐	Prescription Pain Medication
☐	☐	Sleeping Pills
☐	☐	Thyroid Medicine
☐	☐	Tranquilizers
☐	☐	Vitamins
☐	☐	Others ________________________________

Please list all current medications you take below:

Are you ALLERGIC to any of the following medications (do you get hives, a rash, have trouble breathing, etc.):

- ☐ Antibiotics (penicillin, tetracycline, etc .)
- ☐ Local Dental Anesthetics (novacaine)
- ☐ Codeine
- ☐ Aspirin
- ☐ Barbituates or Sedatives
- ☐ Tranquilizers
- ☐ Others ____

	Yes	No
Have you ever had an adverse reaction like nausea, dizziness, or feeling “spacey” with any drug or medication?	☐	☐
Do you have any disease, condition or problem not previously listed that you feel we should know about?	☐	☐

WOMEN:

	Yes	No
Are you currently pregnant? Expected delivery date _____________	☐	☐
Do you take birth control meds?	☐	☐
Are you nursing?	☐	☐
Are you currently on hormone replacement therapy?	☐	☐
Have you had a mammogram? Date __________________	☐	☐

HEALTH HISTORY

Dental Questions:

Are you in any discomfort now? Y N Where?__________________ How long?________________________________

When was your last visit to a dentist?______________________ What was done?__________________________________

How often do you visit a dentist?__________________________ Date of last x-rays?_________________________________

Have you had teeth extracted? Y N Any complications?____

Are your teeth sensitive to Hot Y/N Cold Y/N Sweets Y/N Pressure Y/N

Have you had braces? Y N When?_________ Have you had periodontal (gum) treatments? Y N When?_____________

Have you ever worn a "night guard" ? Y N Do you snore? Y N

How often do you brush your teeth?___________ Do you use an electric brush? Y N Floss? Y N How often?____________

Do you use any other teeth cleaning aids?____

Do your gums ever bleed? Y N When?____

Does food wedge between certain teeth? Y N Where?____

Does your jaw ever click or pop? Y N Where and when?____

Do you get frequent headaches? Y N Do you ever wake-up with a headache? Y N How often?_________________________

Are you aware of any lump or swelling in your mouth? Y N Do you bite your fingernails? Y N

Were you satisfied with your previous dentist? Y N Explain____

What are your expectations of our office?____

What are your goals for your mouth, teeth and smile?____

Are you unhappy with the appearance of your teeth?____

Would you like your smile to look better or different?____

Would you like your teeth to be whiter? Y N

Please circle any of the following which have kept you from having the best dental care possible:

Fear of Pain   Cost of Treatment   Lack of Concern   Missing Work Time

I certify that I have read and understand the questions above. Any questions that I had in regards to these questions have been answered to my complete satisfaction. I will not hold Dr. St. Clair or any other member of the staff of this office responsible for any errors or omissions that I may have made in completion of this form. I will advise this office and Dr. St. Clair of any changes in my physical, dental or general health condition as well as changes in my medications.

____   ____
Signature (parent/guardian)   Date

HEALTH HISTORY