# Dental Health History Form

**Name of Patient** _____ **Date** _____

Our goal at Pacific Dental Care is to work with you to create a healthy and attractive smile you deserve. It's all about you! Please complete this form so that we can better know how to provide you with the best and most advanced dental care in our relaxing spa setting.

**Answers to the following questions are for our records only and will be considered confidential.**

1. Have you or any member of your family been seen by us before? ☐Yes ☐No

   If yes, which family member(s)? _____

2. Date of last physical examination: _____ Physician's Name & Phone #: _____

3. Date of last dental visit and teeth cleaning _____

4. Have you been hospitalized in the past two years? ☐Yes ☐No

6. Have you ever had any excessive bleeding requiring special treatment? ☐Yes ☐No

7. Have you ever taken Redux or Pondimin (Fen Phen)? ☐Yes ☐No

8. Have you had any operations? ☐Yes ☐No

   If YES, explain _____

## Medications

Please list medications you are currently taking (i.e., Aspirin, Coumadin, Plavix, Nicotine Patch, NSAID's, etc.):

_____

_____

## Allergies

| | | | | | |
|---|---|---|---|---|---|
| Aspirin: | ☐ | Local Anesthesia: | ☐ | Barbiturate: | ☐ |
| Iodine: | ☐ | Codeine: | ☐ | Sulfa: | ☐ |
| Penicillin: | ☐ | Erythromycin: | ☐ | Latex: | ☐ |
| Metals: | ☐ | | | Other: _____ | |

**Place a mark "Yes" or "No" to indicate if you have had any of the following:**

| | YES | No | | YES | No | | YES | No |
|---|---|---|---|---|---|---|---|---|
| AIDS | ☐ | ☐ | Eating Disorder | ☐ | ☐ | Kidney Disease | ☐ | ☐ |
| Alcoholism | ☐ | ☐ | Epilepsy/Seizures | ☐ | ☐ | Liver Disease | ☐ | ☐ |
| Anemia | ☐ | ☐ | Fainting/Dizziness | ☐ | ☐ | Mental Retardation | ☐ | ☐ |
| Any Implants | ☐ | ☐ | Glaucoma | ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ |
| Arthritis | ☐ | ☐ | Headaches | ☐ | ☐ | Narcotic Drugs | ☐ | ☐ |
| Artificial Heart Valves | ☐ | ☐ | Heart Disease | ☐ | ☐ | Pacemaker | ☐ | ☐ |
| Artificial Joints | ☐ | ☐ | Heart Surgery | ☐ | ☐ | Persistent Cough | ☐ | ☐ |
| Asthma | ☐ | ☐ | Heart Attack | ☐ | ☐ | Psychiatric Therapy | ☐ | ☐ |
| Birth Defects | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Steroid Treatment | ☐ | ☐ |
| Blood Disease | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Rheumatic Fever | ☐ | ☐ |
| Bruise Easily | ☐ | ☐ | Hepatitis A | ☐ | ☐ | Radiation Therapy | ☐ | ☐ |
| Cancer | ☐ | ☐ | Hepatitis B | ☐ | ☐ | Shortness of Breath | ☐ | ☐ |
| Chemotherapy | ☐ | ☐ | Hepatitis C | ☐ | ☐ | Thyroid Disease | ☐ | ☐ |
| Cold Sores | ☐ | ☐ | Herpes Simplex | ☐ | ☐ | Tobacco Use | ☐ | ☐ |
| Congenital Heart Disease | ☐ | ☐ | HIV Positive | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Hives or Skin Rash | ☐ | ☐ | Ulcers | ☐ | ☐ |
| Drug Addiction | ☐ | ☐ | Jaundice | ☐ | ☐ | | | |

**Have you ever experienced any of the following problems with your jaw?**

| | | |
|---|---|---|
| Clicking/Clenching/Grinding | ☐Yes | ☐No |
| Pain in or around ears and/or headaches | ☐Yes | ☐No |
| Difficulty opening or closing | ☐Yes | ☐No |
| Difficulty chewing | ☐Yes | ☐No |
| Do you have history of trauma to your jaw | ☐Yes | ☐No |
| Have you ever been diagnosed with TMJ/TMD | ☐Yes | ☐No |

**Do you have any of the problems listed below?**

Swelling / Bleeding Gums ☐Yes ☐No

Bad Taste/Odor (Halitosis) ☐Yes ☐No

Loose Teeth ☐Yes ☐No

**Do you have sensitivity to:**

Temperature (Hot or Cold) ☐Yes ☐No

Biting / Pressure ☐Yes ☐No

Sweet ☐Yes ☐No

Have you ever had any lumps or growths in or near your mouth? ☐Yes ☐No

Have you ever had prolonged bleeding following extractions? ☐Yes ☐No

Have you ever needed to see a Periodontist (Gum Specialist)? ☐Yes ☐No

Do you notice bleeding gums when you brush? ☐Yes ☐No

Are you having any pain or discomfort at this time? ☐Yes ☐No

Do you feel nervous about having dental treatment? ☐Yes ☐No

Have you ever had a bad experience in a dental office? ☐Yes ☐No

Is there anything you dislike about your smile? ☐Yes ☐No

**Is there anything related to your medical and/or dental history that you have not indicated above?**

_____

**For Women:**

Are you taking oral contraceptives? ☐Yes ☐No

Are you **pregnant** now? ☐Yes ☐No

Are you currently breast-feeding? ☐Yes ☐No

I certify that the above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information (including diagnosis and records of any treatment or examination rendered to me or my child) to third party payers and/or healthcare practitioners. I authorize and request my insurance company to directly reimburse the dentist or dental group any benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf, or on behalf of my dependents. I consent to photographs being taken and understand that they may be used for illustration and documentation of my treatment.

X_____

**Signature of Patient or Guardian**

X _____

**Signature of Dentist**