Happy Smiles Family Dentistry

Health and Dental History

Today's Date: _____ Appointment Date: _____ Time: _____

Patient Name:_____Nickname:_____ Birth Date:_____
Last First MI

Parent/Guardian (if applicable):_____ Patient Age:_____ ____Male ____Female

___ Married ___Single ___Child ___Other

Phone Numbers:

*Home:*_____ *Work:*_____ *Cell:*_____

Email Address: _____

HomeAddress:_____

City: _____ State: _____ Zip: _____SSN#_____

Health Information

Date of Last Dental Visit: _____ Reason for Visit:_____

Are You Currently in Any Dental Pain Right Now? Yes No
If yes, Please explain_____

Have You Ever Had Any Complications During or Following Dental Treatment? Yes No
If Yes, Please Explain:_____

Are You Unhappy About Your Smile? Yes No
If Yes, Please Explain:_____

Have You Had Braces? Yes No
If Yes, Please List Orthodontist's Name and Number:_____

Are You Aware of Having an Allergic Reaction to Any Medication or Substance? Yes No
If Yes, Please Explain:_____

Do You Smoke or Drink? Yes No
If Yes, Please Explain:_____

Are You Taking/Using any Recreational Drugs? Yes No
If Yes, Please Explain:_____

Have You Been Admitted to the Hospital or Needed Emergency Care During The Past Two Years? Yes No
If Yes, Please Explain:_____

Are You Taking Birth Control Pills? Yes No
If Yes, Please Provide Name:_____

Are you Pregnant, or Trying to Become Pregnant? Yes No

If Yes, How Many Weeks?_____

When is Your Due Date?_____

Are you Nursing? Yes No

Are You now Under The Care of a Physician? Yes No

If Yes, Please Explain:_____

Are You Taking Any Medications? Yes No

If Yes, Please List Name And Dose:_____

PLEASE LIST ANY MEDICATION YOU MAY BE CURRENTLY TAKING

MEDICATION	DOSAGE	HOW OFTEN	ROUTE (ORAL/INJECTION)	WHAT IS MEDICATION TAKEN FOR?

MEDICAL HISTORY CONTINUED

HAVE YOU EVER EXPERIENCED OR HAD ANY OF THE FOLLOWING? PLEASE MARK YES OR NO TO EACH ITEM.

AIDS/HIV	□Yes □No		Hepatitis A B C or D	□Yes □No
Allergies	□Yes □No		Herpes	□Yes □No
Anemia	□Yes □No		High Blood Pressure	□Yes □No
Arthritis/Rheumatism	□Yes □No		Hives/Rash	□Yes □No
Artificial Joints	□Yes □No		Insomnia/Frequent Waking	□Yes □No
Artificial Heart Valve	□Yes □No		Jaundice	□Yes □No
Asthma	□Yes □No		Kidney Disease	□Yes □No
Autism	□Yes □No		Liver Disease	□Yes □No
Back Problems	□Yes □No		Mental Illness	□Yes □No
Bell's Palsy	□Yes □No		Multiple Sclerosis	□Yes □No
Bladder Disease/Problems	□Yes □No		Nervous Problems	□Yes □No
Bleeding Problems	□Yes □No		Prosthetic Heart Valve	□Yes □No
Blood Transfusions	□Yes □No		Psychiatric Care	□Yes □No
Bruise Easily	□Yes □No		Radiation Treatment	□Yes □No
Cancer	□Yes □No		Respiratory Problems	□Yes □No
Circulatory Problems	□Yes □No		Rheumatic Fever	□Yes □No
Chemotherapy	□Yes □No		Ringing of Ears	□Yes □No
Chest Pain	□Yes □No		Sexually Transmitted Disease	□Yes □No
Crohn's Disease	□Yes □No		Shingles	□Yes □No
Congested Ears	□Yes □No		Sickle Cell Disease	□Yes □No
COPD	□Yes □No		Sinus Problems	□Yes □No
Diabetes	□Yes □No		Skin Rash/Disease	□Yes □No
Dizziness or Fainting	□Yes □No		Stomach Problems	□Yes □No
Down Syndrome	□Yes □No		Stroke	□Yes □No
Epilepsy	□Yes □No		Surgeries	□Yes □No
Fibromyalgia	□Yes □No		Swelling of the Limbs	□Yes □No
Glaucoma	□Yes □No		Thyroid Problems	□Yes □No
Gout	□Yes □No		Tingling in Arms/Fingers	□Yes □No
Headaches	□Yes □No		Tuberculosis	□Yes □No
Heart Attack	□Yes □No		Tumor or Growths	□Yes □No
Heart Murmur	□Yes □No		Ulcers	□Yes □No
Heart Pacemaker	□Yes □No		Weight Loss/Gain	□Yes □No

Do you have or have you had any disease, condition or problem not listed? Yes No

If Yes, Please Explain:_____

Do any of the Following Dental Concerns Apply to you?

Bad Breath	□Yes □No
Bleeding Gums	□Yes □No
Blisters on Lips or Mouth	□Yes □No
Burning Sensation on Tongue	□Yes □No
Clicking or Popping Jaw and or swollen/tender	□Yes □No
Clenching or Grinding of Your Teeth	□Yes □No
Dry Mouth	□Yes □No
Food Collecting/Packing Between Teeth	□Yes □No
Lip or Cheek Biting	□Yes □No
Loose or Broken Teeth	□Yes □No
Loose or Broken Fillings/Crowns	□Yes □No
Missing Teeth	□Yes □No
Sensitivity to Pressure or Other: (cold, heat, sweets)	□Yes □No
Stained/Darker Than Normal Teeth	□Yes □No
Spaces/Gaps Between Teeth	□Yes □No
Tooth Ache(s)	□Yes □No
Other Dental Concerns (Please List):	□Yes □No

I have answered all the questions to the best of my knowledge. Should further information be needed, I grant permission to ask my respective healthcare providers or agencies, who may release information to you. I will notify the dentist of any changes in my heath or medication.

_____ _____

Patient, parent, or legal guardian signature Date