Smile Center

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HEALTH HISTORY

Name: _____ Physician's Name: _____
Date Of Last Medical Exam: _____ Phone: _____

Please answer each question relative to your health. Check YES or NO.

	YES	NO
1. Are you in good health now?	☐	☐
2. Are you now under the care of a physician?	☐	☐
If so, what is the condition being treated? _____		
3. Have you ever had any unusual effect from any previous dental treatment?	☐	☐
4. Have you ever had excessive bleeding following the extraction, or do cuts take longer to heal now than previously?	☐	☐
5. Is your drinking water fluoridated?	☐	☐
6. Have you ever been told you need antibiotics prior to dental treatment?	☐	☐
If so, why? _____		

7. Are you ALLERGIC or have you ever experienced any reaction to the following?

	YES	NO		YES	NO
Aspirin or Codeine	☐	☐	Local Anesthetics (e.g.) novocaine)	☐	☐
Barbiturates/Sedatives/Sleeping Pills	☐	☐	Penicillin/Other Antibiotics	☐	☐
Jewelry/Metal	☐	☐	Sulfa Drugs	☐	☐
Latex	☐	☐	Other Allergies _____		

8. Are you taking medication at the present time?	☐	☐
If so, please list: _____		

9. Do you have or have you ever had the following?

	YES	NO		YES	NO
Anemia	☐	☐	Heart Attack/Trouble	☐	☐
Artificial Heart Valve	☐	☐	Heart Murmur	☐	☐
Artificial Joint	☐	☐	Hepatitis	☐	☐
Asthma/Hay Fever	☐	☐	High Blood Pressure	☐	☐
Bronchitis	☐	☐	Hip Surgery	☐	☐
Cancer Treatment	☐	☐	HIV + Virus (Aids)	☐	☐
Congenial Heart Disease	☐	☐	Kidney Trouble	☐	☐
Convulsions	☐	☐	Mitral Valve Prolapse	☐	☐
Diabetes	☐	☐	Orthodontics	☐	☐
Environmental Allergies	☐	☐	Pacemaker	☐	☐
Faint Easily	☐	☐	Psychiatric Treatment	☐	☐
Family History Of Diabetes	☐	☐	Rheumatic Fever	☐	☐
Frequent Headaches	☐	☐	Tuberculosis	☐	☐
Hearing/Speech Impairment	☐	☐	Venereal Disease	☐	☐
			Other _____		

10. Does dental treatment make you nervous? No _____ Slightly _____ Moderately _____ Extremely _____

11. Do you have or have you ever had any of the following?

MOUTH	YES	NO	TEETH	YES	NO
Bleeding, Sore Gums	☐	☐	Clenching/Grinding	☐	☐
Clicking/Popping Jaw	☐	☐	Difficulty Opening or Closing Jaw	☐	☐
Swelling/Lumps In Mouth.	☐	☐	Sensitive To Biting	☐	☐
Unpleasant Taste/Bad Breath.	☐	☐	Sensitive To Hot/Cold/Sweets	☐	☐

12. Please answer yes or no for consent to the following for the purpose of dental treatment:
____ Fluoride ____ Radiographic Examination (x-rays) for the purpose of dental treatment
____ Local Anesthetic (injections) ____ Nitrous Oxide (gas) ____ Consultation with other doctors

I have completed and reviewed the above questionare. All statements are true to the best of my knowledge. I consent to all necessary dental treatment of my child. I understand that I am responsible for all costs of dental treatment. If I ever have a change in my child's health or medication, I will inform the dentist at the next appointment.

Parent or Guardian Signature _____ Date _____