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. (Women) Are you pregnant? If so, give due date? _____	☐	☐
6. Do you use tobacco in any form? If yes, how much _____	☐	☐
7. Have you ever been told you need antibiotics prior to dental treatment?	☐	☐
If so, why? _____		
8. Are you happy with the color of your teeth?	☐	☐

9. 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 _____		

10. Are you taking medication at the present time, including diet/herbal medicines?	☐	☐
If so, please list: _____		

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

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

12. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____
If so, when? _____

13. 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	☐	☐

14. Please answer yes or no for consent to the following for the purpose of dental treatment:
____ Local Anesthetic (injections) ____ Nitrous Oxide (gas) ____ Both ____ Nothing

I give my consent to radiographic examination (x-rays) for the purpose of dental diagnosis. I give my consent to use local anesthesia, nitrous oxide analgesia, and relaxants for the purpose of having the necessary dental treatment completed. I give consent to Dr. Mehdi Sadeghi to acquire necessary consultation with other dentists regarding my treatment. I understand that I am responsible for all costs of dental treatment. To the best of my knowledge, all of the proceeding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment

Signature of Patient _____ Date _____