**PATIENT HEALTH HISTORY**

Your Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today's Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­

Previous Dentist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Dental Visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_

Are you currently under the care of a physician?  YES  NO

Name of Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a serious illness, operation or been hospitalized in the past 5 years?  Yes  No

Has a physician/previous dentist recommended that you take antibiotics prior to dental treatment?

 Yes  No

**Have you ever had an allergic reaction to**: ***(Check all that apply)***  No Known Allergies

 Metal  Iodine  Latex

 Local Anesthetics/Numbing  Codeine  Food/Flavoring \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Pain-Relievers (Tylenol, Motrin, Aleve, Aspirin)  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_

 Antibiotics (Penicillin, Sulfa, etc)

**Have you ever had any of the following: *(Check all that apply)***

 Artificial (prosthetic) heart valve  Congenital Heart Disease (CHD)

 Previous Infective Endocarditis  Unrepaired, Cyanotic CHD

 Damaged Valves in Transplanted Heart  Repaired (completely) in last 6 months

 Repaired CHD with residual defects

**Please indicate if you currently are taking:**

 Blood Thinners (e.g Coumadin, Plavix, Eliquis)? If so, score of most recent INR\_\_\_\_\_\_\_\_­­\_\_

 Anti-Seizure, Blood Pressure, and/or Immunosuppressant Medications?

 Bisphosphonates (oral or injection) for osteoporosis? (Actonel, Fosamax, Boniva, Aredia, Zometa, etc)

**Have you ever been treated for any of the following medical conditions? *(Check all that apply)***

 Asthma  Alzheimer’s Disease  Cold Sores/Fever Blisters  Autoimmune disease

 Blood disorder  Epilepsy/Seizures  Total Joint Replacement  Arthritis

 Hepatitis/Liver  Tuberculosis  HIV/AIDS  Thyroid problems

 Cancer  Chemo/Radiation  Sleep Apnea  Steroid Use

 Kidney Problems  Psychiatric Therapy  Pacemaker  Ulcers

 Eating Disorder  Sinus Problems  Acid Reflux/Heart Burn  Headaches/Migraines

 Breathing/COPD  Vertigo  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_

**FEMALES ONLY-are you:**

 Pregnant-Number of weeks: \_\_\_\_\_\_\_\_  Taking birth control or hormonal replacement

 Nursing  Post-menopausal

**DENTAL HISTORY**

Rate your level of anxiety/stress/fear when going to the dentist?  None  Mild  Mod  Severe

Are you currently experiencing dental pain or discomfort?  Yes  No

Does food or floss catch between your teeth?  Yes  No

Do your gums bleed when you brush or floss?  Yes  No

Do you have problems with bad breath?  Yes  No

Is your mouth dry?  Yes  No

Have you ever had orthodontic treatment (braces)?  Yes  No

Have you ever had complications after a tooth extraction?  Yes  No

Have you had any adverse reactions to nitrous oxide (laughing gas?)  Yes  No

Are your teeth sensitive to  Hot  Cold  Pressure  Sweets  None

Do you snore?  Yes  No

Do you have any popping/clicking/pain near your ear when you chew?  Yes  No

Do you participate in active recreational activities?  Yes  No

Do you clench or grind your teeth?  Yes  No  Not sure

Is your home water supply fluoridated?  Yes  No  Not sure

Do you have any sores or ulcers in your mouth?  Yes  No  Not sure

Do you wear dentures or partial dentures?  Yes  No

Have you ever had a serious injury to your head or mouth?  Yes  No

**GUM DISEASE RISK ASSESSMENT FORM**

**Tobacco Use**   Yes  No

Type (cigarette, pipe, cigar, chew, e-cig/vape)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much per day? \_\_\_\_\_\_\_\_\_\_\_\_\_ When did you start? \_\_\_\_\_\_\_\_\_\_\_\_

Are you interested in quitting?  Yes  No

**Diabetes**  Yes  No

 Type 1  Type 2  Gestational

Last A1c Score? \_\_\_\_\_\_\_\_\_\_\_

Who is your Diabetes Doctor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cardiovascular Disease/Stroke**

Have you ever suffered a heart attack/stroke?  Yes  No Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any of these risk factors?

 Family history of heart disease  Overweight/High BMI  High Cholesterol

 High Blood Pressure  Angina  Arteriosclerosis

**Genetics**

Have you ever been treated for gum disease?  Yes  No

Do you have any family history of gum disease/tooth loss?  Yes  No  Not Sure

Is anyone in your immediate family being treated for gum disease?  Yes  No

**Stress**

Are you currently going through a life-altering event?  Yes  No

(job loss, divorce, death of a loved one, moving, etc)