SANTA MONICA DENTALCARE

Health history form

NAME DATE

WE WOULD LIKE TO GET TO KNOW YOU BETTER!

Marital Status

Occupation

Employer

Driver's License #

Work Schedule

Emergency Contact Name *

Emergency Contact Phone # *

Would you like to receive text messages regarding reminders on your appointments,

O Yes O No

Cell Phone #:

How did you hear about us? *

When was your last dental appointment? *

Why did you leave your last dentist? *

Who is financially responsible for your dental investment? *

WE WANT TO TAKE CARE OF YOUR NEEDS...

Tell us about your current dental problems: *

Do you avoid brushing any part of your mouth? O Yes O No *

Do your gums bleed when you brush? O Yes O No *

Does dental treatment make you feel nervous? *

Are you dissatisfied with your teeth and their appearance? O Yes O No *

I want to know about current technology that may have a higher fee. O Yes O No *

I think my dental health is... *

I would like my teeth whiter: O Yes O No *

I would like my teeth straighter: O Yes O No *

I would like to close spaces in my teeth: O Yes O No *

I would like to repair chips in my teeth: O Yes O No *

Would you like to remove and replace any mercury/amalgam/silver fillings? O Yes O No *

Are your teeth sensitive to sweets, hot/cold, or biting pressure? O Yes O No *

Help us understand what else your dentist should know:

YOUR MEDICAL HISTORY

Are you in good health?	○ Yes ○ No *
Has there been any change in your general health?	○ Yes ○ No *
My last physical exam was:	_____ *
Have you had a serious illness or operation?	○ Yes ○ No *
Have you had surgery or x-ray treatment for a tumor, growth or other condition of the mouth or lips?	○ Yes ○ No *
Are you now under the care of a physician?	○ Yes ○ No *
Have you ever required a blood transfusion?	○ Yes ○ No *
Have you been hospitalized or had serious illness within the past five (5) years?	○ Yes ○ No *
Have you had any serious problems associated with previous dental treatment?	○ Yes ○ No *
Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?	○ Yes ○ No *
Do you have any implants and/or Prothesis (i.e. hip replacements, knee joints, elbow pins, etc.)?	○ Yes ○ No *
Do you smoke or use tobacco products?	○ Yes ○ No *
Are you thirsty much of the time?	○ Yes ○ No *
Does your mouth frequently become dry?	○ Yes ○ No *
Does your jaw pop or click when opening or chewing?	○ Yes ○ No *
Has your jaw ever been stuck open or closed?	○ Yes ○ No *

GENDER SPECIFIC QUESTIONS

Are you pregnant or could you be?	○ Yes ○ No *
Are you nursing?	○ Yes ○ No *
Oral contraceptives?	○ Yes ○ No *

SPECIALIST SPECIFIC QUESTIONS

Height:	ft: ____ in: ____ *
Weight:	____ lbs *
Have your wisdom teeth been extracted?	○ Yes ○ No *
When were they extracted:	_____ *
Do you have Porphyria (blood disorder)?	○ Yes ○ No *
Have you or anyone else in your family had malignant hyperthermia or other complications while under general anesthesia?	○ Yes ○ No *
Do you have habits such as nail biting, pencil biting, or lip biting?	○ Yes ○ No *
Do you have habits such as thumb sucking or mouth breathing?	○ Yes ○ No *
Do you clench or grind your teeth?	○ Yes ○ No *

DRUGS AND MEDICATIONS

Are you taking any drugs or medications? ○ Yes ○ No *

Please select all that apply

- Antibiotics or sulfa drugs? ☐
- Aspirin? ☐
- Insulin, tolbutamide (Orinase), or similar drug? ☐
- Anticoagulants (blood thinners)? ☐
- Medicine for high blood pressure? ☐
- Cortisone (steroids)? ☐
- Digitalis or drugs for heart trouble? ☐
- Nitroglycerin? ☐
- Tranquilizers? ☐
- Fen-Phen (now, or in the past) or any related drugs such as Ionimin, Adipex, Phentermine, Fastin, Pondimin (Fenfluramin), and Redux (dexfenfluramine)? ☐
- Osteoporosis, chemotherapy or multiple myeloma medications (Bisphosphonates) such as Actonol, Boniva, Fosomax, Skelid and Bonefos? Hormone therapy/replacement? ☐
- Hormone therapy/replacement? ☐
- Recreational or non-prescribed drugs? ☐
- Other? ☐

EXISTING CONDITIONS

Do you have any existing medical conditions?

HEART

○ Yes ○ No (ex. Heart attack, Heart murmur and Stroke) *

Please select all that apply

- Heart transplant? ☐
- Cardiovascular disease (heart trouble, heart attack, coronary occlusion, high blood pressure, arteriosclerosis, stroke)? ☐
- Congestive Heart failure? ☐
- Myocardial infarction? ☐
- Rheumatic fever or rheumatic heart disease? ☐
- Heart murmur/ MVP – Mitral Valve Prolapse? ☐
- High Blood pressure? ☐
- Low Blood pressure? ☐
- Heart surgery, Bypass, Stents? ☐
- Artificial Heart valves? ☐
- Pacemaker? ☐
- Stroke? ☐
- Other? ☐

LUNGS

○ Yes ○ No (ex. Emphysema, Asthma and Bronchitis) *

Please select all that apply

- Emphysema? ☐
- Tuberculosis? ☐
- Asthma? ☐
- Bronchitis? ☐
- Hay fever? ☐
- Chronic cough? ☐
- Difficulty breathing? ☐
- Other?

LIVER

○ Yes ○ No (ex. Hepatitis) *

Please select all that apply

- Hepatitis A (infectious)? ☐
- Hepatitis B (serum)? ☐
- Hepatitis C? ☐
- Jaundice or Liver disease? ☐
- Other?

KIDNEY

○ Yes ○ No (ex. Dialysis) *

Please select all that apply

- Kidney transplant? ☐
- Dialysis treatment? ☐
- Frequent urination? ☐
- Other?

GASTROINTESTIONAL

○ Yes ○ No (ex. Ulcers, Reflux and Gastric Bypass) *

Please select all that apply

- Ulcers? ☐
- Diverticulitis? ☐
- Bowel problems? ☐
- Gastric Bypass? ☐

Reflux/Heartburn GERD? ☐

Eating Disorder? ☐

Other?

BLOOD/ENDOCRINE

○ Yes ○ No (ex. AIDS, Anemia and Diabetes) *

Please select all that apply

AIDS or HIV+? ☐

Hemophilia? ☐

Sickle Cell disease? ☐

Diabetes? ☐

Hypoglycemia? ☐

Anemia? ☐

Thyroid? ☐

Sexually transmitted diseases? ☐

Other?

MENTAL HEALTH/NERVOUS DISORDERS

○ Yes ○ No (ex. Epilepsy, Anxiety and ADHD/ADD) *

Please select all that apply

Depression? ☐

Sleep disorder? ☐

Epilepsy/Seizures? ☐

Fibromyalgia? ☐

Mental Health problems? ☐

Schizophrenia? ☐

Anxiety? ☐

Bi-polar? ☐

Autism? ☐

ADHD/ADD Attention Deficit? ☐

Other?

OTHER

○ Yes ○ No (ex. Cancer, Chemotherapy and Arthritis) *

Please select all that apply

Cancer? ☐

Sinus trouble? ☐

Cold sores?	☐
Radiation therapy?	☐
Chemotherapy?	☐
Severe headaches/Migraines??	☐
Delayed healing?	☐
Contact lenses?	☐
Chronic fatigue?	☐
Inflammatory rheumatism (painful, swollen joints)?	☐
Arthritis?	☐
Other?	

ALLERGIES

Do you have any allergies or have you reacted adversely to anything in the past? ○ Yes ○ No *

Please select all that apply

Local anesthetic?	☐
Aspirin?	☐
Penicillin or other antibiotics	☐
Codeine or other narcotics?	☐
Iodine?	☐
Barbiturates, sedatives, or sleeping pills?	☐
Latex?	☐
Hives or skin rash?	☐
Sulfa drugs?	☐
Asthma or hay fever?	☐
Metal?	☐
Eggs?	☐
Soybean?	☐
Other?	

Signature

I certify that the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health and I will not hold my Dentist or any members of his/her Dental Team responsible for errors or emissions that I have made in completion of this form. It is my responsibility to notify my Dentist of any changes in the above medical status.

Patient or Responsible Party Signature: X _____ Date: _____