**DeCarolis Dental Associates, P.C.**

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# HEALTH HISTORY

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name _____ Birthdate _____ Age _____

**Please answer each question. Check yes or no. If in doubt, leave blank.**

| | | YES | NO |
|---|---|---|---|
| 1. | Are you in good health now? ..... | _____ | _____ |
| 2. | Are you presently under the care of a physician? ..... . If so, what is the condition being treated? _____ | _____ | _____ |
| 3. | Have you ever been hospitalized or had a serious illness? ……..…….. If yes, explain_____ | _____ | _____ |
| 4. | Have you ever had excessive bleeding following an extraction, or do cuts take longer than normal to heal? .. | _____ | _____ |
| 5. | (Women) Are you pregnant? If so, give due date_____ | _____ | _____ |
| 6. | Do you use tobacco in any form? If yes, how much_____ | _____ | _____ |
| 7. | Do you drink more than two alcoholic beverages per day? ..... | _____ | _____ |

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

| Yes | No | |
|---|---|---|
| | | **GENERAL** |
| ___ | ___ | Tire easily, weakness |
| ___ | ___ | Marked weight change |
| ___ | ___ | Night sweats |
| ___ | ___ | Persistent fever |
| | | **SKIN** |
| ___ | ___ | Eruptions (rash) hives |
| ___ | ___ | Change in skin color |
| | | **EYES** |
| ___ | ___ | Visual change |
| ___ | ___ | Glaucoma |
| | | **EARS** |
| ___ | ___ | Loss of hearing |
| ___ | ___ | Ringing in ears |
| | | **NOSE** |
| ___ | ___ | Frequent nosebleeds |
| ___ | ___ | Sinus problems |
| | | **THROAT** |
| ___ | ___ | Soreness/hoarseness |
| | | **NERVOUS SYSTEM** |
| ___ | ___ | Stroke |
| ___ | ___ | Headaches |
| ___ | ___ | Convulsions/epilepsy |
| ___ | ___ | Numbness/tingling |
| ___ | ___ | Dizziness/fainting |
| ___ | ___ | Psychiatric treatment |
| | | **RESPIRATORY** |
| ___ | ___ | Tuberculosis |
| ___ | ___ | Emphysema |
| ___ | ___ | Asthma/hay fever |
| ___ | ___ | Persistent cough |
| ___ | ___ | Sputum production (phlegm) |
| ___ | ___ | Cough up bloody sputum |
| ___ | ___ | Difficulty breathing while lying down |
| | | **ENDOCRINE** |
| ___ | ___ | Diabetes |
| ___ | ___ | Family history of diabetes |
| ___ | ___ | Thyroid condition/goiter |
| ___ | ___ | Other |

| Yes | No | |
|---|---|---|
| | | **HEART/BLOOD VESSELS** |
| ___ | ___ | Rheumatic fever |
| ___ | ___ | Heart murmur |
| ___ | ___ | Mitral valve prolapse |
| ___ | ___ | Chest pain/discomfort |
| ___ | ___ | Heart attack |
| ___ | ___ | Shortness of breath |
| ___ | ___ | Swelling of ankles |
| ___ | ___ | High blood pressure |
| ___ | ___ | Congenital heart disease |
| ___ | ___ | Artificial heart valve – Date of surgery_____ |
| ___ | ___ | Pacemaker – Date of surgery_____ |
| ___ | ___ | Heart surgery – Date_____ |
| | | Other_____ |
| | | **BONE/MUSCLES** |
| ___ | ___ | Arthritis/rheumatism |
| ___ | ___ | Artificial joint(s) – Date of surgery_____ |
| | | **DIGESTIVE SYSTEM** |
| ___ | ___ | Hepatitis |
| ___ | ___ | Jaundice |
| ___ | ___ | Ulcers |
| ___ | ___ | Change in appetite |
| ___ | ___ | Black, bloody, or pale stool |
| | | **URINARY** |
| ___ | ___ | Kidney disease |
| ___ | ___ | Increase in frequency of urination (night) |
| ___ | ___ | Burning on urination |
| ___ | ___ | Urethral discharge |
| ___ | ___ | Bloody urine |
| ___ | ___ | Venereal disease |
| | | **BLOOD** |
| ___ | ___ | Bruise easily |
| ___ | ___ | Anemia |
| ___ | ___ | Blood transfusion – Date_____ |
| | | **OTHER** |
| ___ | ___ | Radiation therapy |
| ___ | ___ | Tumors or growths |
| ___ | ___ | Cancer |
| ___ | ___ | AIDS |
| ___ | ___ | HIV positive |

9. Are you ALLERGIC or have you ever experience any reaction to the following?

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ___ | ___ | Local anesthetic (e.g. novocaine) | ___ | ___ | Aspirin or codeine |
| ___ | ___ | Barbiturates/sedative/sleeping pills | ___ | ___ | Sulfa drugs |
| ___ | ___ | Penicillin/other antibiotics - _____ | ___ | ___ | Other allergies_____ |

10. Are you taking any of the following?

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ___ | ___ | Antibiotics/sulfa drugs | ___ | ___ | Tranquilizers |
| ___ | ___ | Blood thinners | ___ | ___ | Insulin/other diabetes drugs |
| ___ | ___ | Blood pressure medication | ___ | ___ | Recreational drugs |
| ___ | ___ | Thyroid medicine | ___ | ___ | Digitalis/other heart medications |
| ___ | ___ | Cortisone/steroids | ___ | ___ | Nitroglycerin |
| ___ | ___ | Antihistamines/allergy drugs/cold remedies | ___ | ___ | Aspirin |
| ___ | ___ | Other_____ | | | |

Name and dosage of the medications being taken:

_____ _____
_____ _____
_____ _____

11. Is there any disease, condition, or problem not listed on this form that you think we should know about, or is there any activity your physician says you cannot do?_____
12. Physician's name_____Phone_____
13. Have you ever had any serious trouble associated with previous dental treatment?_____
    _____
14. Does dental treatment make you nervous? NO_____ Slightly_____ Moderately_____ Extremely_____
15. Previous Dentist Name _____Date of last dental visit _____
16. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)?_____If so, when?_____

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

| Yes | No | MOUTH | Yes | No | TEETH |
|---|---|---|---|---|---|
| ___ | ___ | Bleeding, sore gums | ___ | ___ | Loose teeth |
| ___ | ___ | Unpleasant taste/bad breath | ___ | ___ | Sensitive to hot |
| ___ | ___ | Burning tongue/lips | ___ | ___ | Sensitive to cold |
| ___ | ___ | Frequent blisters on lips/in mouth | ___ | ___ | Sensitive to sweets |
| ___ | ___ | Swelling/lumps in mouth | ___ | ___ | Sensitive when biting |
| ___ | ___ | Ortho treatments (Braces) | ___ | ___ | Food impaction |
| ___ | ___ | Biting cheeks/lips | ___ | ___ | Clenching/grinding |
| ___ | ___ | Clicking/popping jaw | ___ | ___ | Shifting of teeth |
| ___ | ___ | Difficulty opening or closing jaw | ___ | ___ | Change in bite |

**ORAL HYGIENE – Do you use the following?**

| Yes | No | | |
|---|---|---|---|
| ___ | ___ | Brush | How often do you brush_____ |
| ___ | ___ | Dental floss | |
| ___ | ___ | Fluoride rinse | Brush is: ___Soft ___Medium ___Hard |
| ___ | ___ | Other_____ | |

To the best of my knowledge, all of the preceding 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, Parent, or Guardian Date