JAMES STREET
DENTAL
22 James Street · Geneva, IL 60134 · 630-232-9535

HEALTH HISTORY

NAME_____**BIRTHDATE**_____**TODAY'S DATE**_____

DENTAL HISTORY

Reason for your visit_____

When was your last dental visit?_____

How often do you brush your teeth?_____

What texture brush do you use? ____ Soft ____ Medium ___ Hard

Do your gums bleed while brushing? Y N

Do your gums bleed when flossing? Y N

Do you feel pain to any of your teeth when brushing? Y N

Are your teeth sensitive to hot, cold, sweet or sour foods/liquids? Y N

Have you noticed any loosening of your teeth? Y N

Does food tend to get caught between your teeth? Y N

Do you have any sores or lumps in/near your mouth? Y N

Have you ever experienced any of the following problems in your jaw?

a. Clicking Y N
b. Pain (joint, ear, side of face)? Y N
c. Difficulty in opening or closing? Y N
d. Difficulty in chewing? Y N

Have you had any head, neck or jaw injuries? Y N

Do you bite your lips or cheeks frequently? Y N

Do you clench or grind your teeth while awake? Y N

Do you have frequent headaches? Y N

Have you ever had:

a. Orthodontic treatment (braces)? Y N
b. Oral surgery? Y N
c. Gum treatment? Y N
d. Your teeth bite adjusted? Y N
e. Worn a bite guard or other appliance? Y N

Are you satisfied with the appearance of your teeth? Y N

Have you ever had an upsetting experience in the dental office? Y N

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

Are you in good health? Y N

Have you had any changes in your general health in the past year? Y N

Date of your last physical exam?_____

Physician's name_____
Address_____
Phone No._____

Are you now under the care of a physician? Y N
Name of Pharmacy?_____

Have you ever been hospitalized for any Surgical operation or serious illness? Y N
Please explain_____

Are you taking any medication including non-prescription medication? Y N

If yes, what medication are you taking?_____
_____

Do you drink alcohol? Y N
Do you use recreational drugs? Y N

Have you ever had abnormal bleeding? Y N

Do you bruise easily? Y N

Have you ever required a blood transfusion? Y N

Have you had a recent weight loss? Y N

Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? Y N

Do you use tobacco? Y N

Are you wearing contact lenses? Y N

Do you have any disease, condition or problem not listed above that you think I should know about? Y N
_____

Women Only:

Are you pregnant or think you may be pregnant? Y N

Are you nursing? Y N
Are you taking birth control pills? Y N

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MEDICAL HISTORY CONTINUED...

Are you allergic to or have you had reactions to:

Local anesthetics like novocaine?	Y N
Penicillin or other antibiotics?	Y N
Sulfa drugs?	Y N
Barbiturates, sedatives or sleeping pills?	Y N
Aspirin?	Y N
Latex?	Y N
Other?_____	Y N

Do you have or have you ever had the

Rheumatic heart disease or rheumatic fever?	Y N
Scarlet fever?	Y N
Heart defect or heart murmur?	Y N
Heart trouble, heart attack or angina?	Y N
a. Do you have pain in your chest upon exertion?	Y N
b. Are you ever short of breath after mild exercise?	Y N
c. Do your ankles swell?	Y N
d. Do you get short of breath when you lie down?	Y N
e. Do you require extra pillows when you sleep?	Y N
Pacemaker?	Y N
Heart surgery?	Y N
High blood pressure?	Y N
Low blood pressure?	Y N
Hepatitis, jaundice or liver disease?	Y N
Stroke?	Y N
Sinus trouble?	Y N
Lung or breathing problems?	Y N
Asthma or hay fever?	Y N
Hives or skin rash?	Y N
Fainting spells or seizures?	Y N
Diabetes?	Y N
AIDS or HIV infection?	Y N
Thyroid problems?	Y N
Allergies?	Y N
Arthritis or rheumatism?	Y N
Joint replacement or implant?	Y N
Stomach ulcer?	Y N
Kidney trouble?	Y N
Tuberculosis?	Y N
Persistent cough?	Y N
Cancer?	Y N
Epilepsy?	Y N
Anemia?	Y N
Glaucoma?	Y N
Sleep Apnea?	Y N

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

Signature of patient or guardian Date

For Completion By the Dentist:

SUMMARY OF DENTAL HISTORY

_____
_____
_____
_____

SUMMARY OF MEDICAL HISTORY

_____
_____
_____

MEDICAL HISTORY UPDATE:

DATE	COMMENTS	PATIENT	INITIALS: DENTIST	HYGIENIST
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____