AFFINIA HEALTHCARE

DENTAL HEALTH HISTORY FORM

NAME_____

DOB_____/_____/_____

Physician: _____

Address: _____

_____

Phone: _____

Last Visit Date: _____

Reason for Visit: _____

Medical Alerts: _____

_____

Medications: _____

_____

In an Emergency _____

Contact: _____

Relationship: _____

Phone: _____

Yes	No	MEDICAL HISTORY
☐	☐	1. Are you currently under the care of a physician?
☐	☐	2. Are you currently taking any medications?
☐	☐	3. Have you ever had surgery in a hospital?
☐	☐	4. Have you ever had head, neck or jaw injuries?
☐	☐	5. Do you have eye problems like glaucoma?
☐	☐	6. Heart disease, heart attack, angina, heart surgery, a pacemaker, or irregular beats?
☐	☐	7. High blood pressure?
☐	☐	8. Artificial hip or knee joint?
☐	☐	9. Blood disorders like anemia?
☐	☐	10. Blood bleeding problems after surgery or having a tooth pulled?
☐	☐	11. Cancer, tumors, radiation or chemotherapy?
☐	☐	12. Diabetes?
☐	☐	13. Hepatitis, jaundice or liver disease?
☐	☐	14. Kidney problems or dialysis?
☐	☐	15. Breathing problems like asthma, hay fever?
☐	☐	16. Venereal disease or AIDS?
☐	☐	17. Stroke, convulsions, seizures or fainting spells?
☐	☐	18. Arthritis or rheumatism?
☐	☐	19. Ulcers, heartburn or intestinal disease?
☐	☐	20. Have you been treated for chemical dependency?
☐	☐	21. Have you been treated for psychiatric problems?

Yes	No	MEDICAL HISTORY
☐	☐	22. Are you Allergic to ANY medications?
☐	☐	23. Have you been given local dental anesthetic?
☐	☐	24. Do you have any other medical problems?
		WOMEN ONLY
☐	☐	25. Are you pregnant?
☐	☐	26. Do you take birth control pills?
☐	☐	27. Do you breastfeed?
		CHILDREN ONLY
☐	☐	28. Eye, ear, nose, throat problems?
☐	☐	29. Do you have a cold or flu?
		DENTAL HISTORY
☐	☐	30. How long since your last dental visit? _____
☐	☐	31. What dental work was done? _____
☐	☐	32. Do you have a toothache, sore jaw or swelling?
☐	☐	33. Are teeth sensitive to hot, cold or pressure?
☐	☐	34. Do your gums bleed when you brush?
☐	☐	35. Do you have cold sore or fever blisters?
☐	☐	36. Do you have lumps, bumps, red or white spots in your mouth?
☐	☐	37. Can you chew your food adequately?
☐	☐	38. Are you scared of dentists or dental care?
☐	☐	39. Do you smoke?
☐	☐	40. How often do you brush your teeth? _____

Number	Notes	FOLLOW-UP ON "YES" ANSWERS
_____		_____
_____		_____
_____		_____
_____		_____

To the best of my knowledge, the foregoing questions have been accurately answered.

Date: _____ Relationship: _____

Signature: _____

Date	Dentist	Date	Dentist
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____