

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 _____ Birth Date _____ Age _____

Why are you seeking dental treatment? _____

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

	YES	NO
Are you in good health now? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you now under the care of a physician? If yes, what condition is being treated? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been hospitalized or had a serious illness? If yes, explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
_____ Date of last physical exam: _____		
Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously? _____	<input type="checkbox"/>	<input type="checkbox"/>
(Women) Are you pregnant? If yes, what is your due date? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you nursing? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you use tobacco in any form? If yes, how much? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have more than two alcoholic beverages per day? _____	<input type="checkbox"/>	<input type="checkbox"/>

Do you have now, or have you ever had any of the following?

		YES	NO			YES	NO
GENERAL				HEART/BLOOD VESSELS			
Tire easily, weakness _____	<input type="checkbox"/>		<input type="checkbox"/>	Rheumatic fever _____	<input type="checkbox"/>		<input type="checkbox"/>
Marked weight change (up or down) _____	<input type="checkbox"/>		<input type="checkbox"/>	Heart murmur _____	<input type="checkbox"/>		<input type="checkbox"/>
Night sweats _____	<input type="checkbox"/>		<input type="checkbox"/>	Chest pain/discomfort _____	<input type="checkbox"/>		<input type="checkbox"/>
Persistent fever _____	<input type="checkbox"/>		<input type="checkbox"/>	Heart attack/trouble _____	<input type="checkbox"/>		<input type="checkbox"/>
SKIN				BONE/MUSCLES			
Eruptions (rash), hives _____	<input type="checkbox"/>		<input type="checkbox"/>	Arthritis _____	<input type="checkbox"/>		<input type="checkbox"/>
Change in skin color _____	<input type="checkbox"/>		<input type="checkbox"/>	Artificial joints or limbs _____	<input type="checkbox"/>		<input type="checkbox"/>
EYES				DIGESTIVE SYSTEM			
Visual change _____	<input type="checkbox"/>		<input type="checkbox"/>	Hepatitis _____	<input type="checkbox"/>		<input type="checkbox"/>
Glaucoma _____	<input type="checkbox"/>		<input type="checkbox"/>	Jaundice _____	<input type="checkbox"/>		<input type="checkbox"/>
EARS				URINARY			
Loss of hearing _____	<input type="checkbox"/>		<input type="checkbox"/>	Kidney disease _____	<input type="checkbox"/>		<input type="checkbox"/>
Ringling in ears _____	<input type="checkbox"/>		<input type="checkbox"/>	Increase in frequency of urination (night) _____	<input type="checkbox"/>		<input type="checkbox"/>
NOSE				BLOOD			
Frequent nosebleeds _____	<input type="checkbox"/>		<input type="checkbox"/>	Burned feeling on urination _____	<input type="checkbox"/>		<input type="checkbox"/>
Sinus problems _____	<input type="checkbox"/>		<input type="checkbox"/>	Urethral discharge _____	<input type="checkbox"/>		<input type="checkbox"/>
THROAT				OTHER			
Soreness/hoarseness _____	<input type="checkbox"/>		<input type="checkbox"/>	Radiation therapy _____	<input type="checkbox"/>		<input type="checkbox"/>
NERVOUS SYSTEM				Chemotherapy _____			
Stroke _____	<input type="checkbox"/>		<input type="checkbox"/>	Tumors or growths _____	<input type="checkbox"/>		<input type="checkbox"/>
Headache _____	<input type="checkbox"/>		<input type="checkbox"/>	Cancer _____	<input type="checkbox"/>		<input type="checkbox"/>
Convulsions/epilepsy _____	<input type="checkbox"/>		<input type="checkbox"/>	AIDS _____	<input type="checkbox"/>		<input type="checkbox"/>
Numbness/tingling _____	<input type="checkbox"/>		<input type="checkbox"/>				
Dizziness/fainting _____	<input type="checkbox"/>		<input type="checkbox"/>				
Psychiatric treatment _____	<input type="checkbox"/>		<input type="checkbox"/>				
RESPIRATORY							
Tuberculosis _____	<input type="checkbox"/>		<input type="checkbox"/>				
Emphysema _____	<input type="checkbox"/>		<input type="checkbox"/>				
Asthma/hay fever _____	<input type="checkbox"/>		<input type="checkbox"/>				
Persistent cough _____	<input type="checkbox"/>		<input type="checkbox"/>				
Sputum production (phlegm) _____	<input type="checkbox"/>		<input type="checkbox"/>				
Cough up blood _____	<input type="checkbox"/>		<input type="checkbox"/>				
Difficulty breathing while lying down _____	<input type="checkbox"/>		<input type="checkbox"/>				
ENDOCRINE							
Diabetes _____	<input type="checkbox"/>		<input type="checkbox"/>				
Family history of diabetes _____	<input type="checkbox"/>		<input type="checkbox"/>				
Thyroid condition _____	<input type="checkbox"/>		<input type="checkbox"/>				
Other _____	<input type="checkbox"/>		<input type="checkbox"/>				
HIV positive _____	<input type="checkbox"/>		<input type="checkbox"/>				

Are you ALLERGIC to or have you ever reacted adversely to any of the following?

	YES	NO		YES	NO
Local anesthetics (novocaine) _____	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin _____	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates/sedatives/sleeping pills _____	<input type="checkbox"/>	<input type="checkbox"/>	Codeine _____	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin/other antibiotics _____	<input type="checkbox"/>	<input type="checkbox"/>	Latex gloves _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Other allergies _____	<input type="checkbox"/>	<input type="checkbox"/>

Are you now taking any of the following?

Antibiotics/sulfa drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	Tranquilizers _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood thinners _____	<input type="checkbox"/>	<input type="checkbox"/>	Insulin/other diabetes drugs _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure medication _____	<input type="checkbox"/>	<input type="checkbox"/>	Digitalis/other heart medications _____	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid medicine _____	<input type="checkbox"/>	<input type="checkbox"/>	Nitroglycerine _____	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone/steroids _____	<input type="checkbox"/>	<input type="checkbox"/>	Antihistamines/allergy drugs _____	<input type="checkbox"/>	<input type="checkbox"/>
Cold remedies _____	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin _____	<input type="checkbox"/>	<input type="checkbox"/>
Recreational drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	Pain medicine _____	<input type="checkbox"/>	<input type="checkbox"/>
Birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>	Other medications _____	<input type="checkbox"/>	<input type="checkbox"/>
Bone Replacement Drugs for Osteoporosis _____	<input type="checkbox"/>	<input type="checkbox"/>			

If you answered YES to taking any of the above medications, please list the name of the medication and dosage below:

Is there any other disease, condition, or problem not listed above that we should know about, or is there any activity your doctor says you cannot do? If YES, please explain: _____

Physician's name _____ Phone _____

Address _____

Have you ever had any trouble with any previous dental treatment? _____

Does dental treatment make you nervous? (Circle one) No Slightly Moderately Extremely

Date of last dental visit _____ What was done? _____

Have you ever been treated for gum disease (periodontal disease, pyorrhea) YES NO When? _____

Do you now have or have you ever had:

MOUTH		YES	NO	TEETH		YES	NO
Bleeding, sore gums _____	<input type="checkbox"/>	<input type="checkbox"/>		Loose teeth _____	<input type="checkbox"/>	<input type="checkbox"/>	
Unpleasant taste/bad breath _____	<input type="checkbox"/>	<input type="checkbox"/>		Sensitive to hot _____	<input type="checkbox"/>	<input type="checkbox"/>	
Burning tongue/lips _____	<input type="checkbox"/>	<input type="checkbox"/>		Sensitive to cold _____	<input type="checkbox"/>	<input type="checkbox"/>	
Ulcers/fever blisters, lips/mouth _____	<input type="checkbox"/>	<input type="checkbox"/>		Sensitive to sweets _____	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling, lumps in mouth _____	<input type="checkbox"/>	<input type="checkbox"/>		Sensitive to biting (pressure) _____	<input type="checkbox"/>	<input type="checkbox"/>	
Braces/orthodontic appliances _____	<input type="checkbox"/>	<input type="checkbox"/>		Food impaction (getting stuck between) _____	<input type="checkbox"/>	<input type="checkbox"/>	
Biting cheeks/lips _____	<input type="checkbox"/>	<input type="checkbox"/>		Clenching/grinding _____	<input type="checkbox"/>	<input type="checkbox"/>	
Clicking/popping in jaw _____	<input type="checkbox"/>	<input type="checkbox"/>		Shifting of teeth _____	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty opening or closing jaw _____	<input type="checkbox"/>	<input type="checkbox"/>		Change in bite _____	<input type="checkbox"/>	<input type="checkbox"/>	
Do you snore _____	<input type="checkbox"/>	<input type="checkbox"/>					

ORAL HYGIENE (DO YOU USE):

Tooth brush (___ times per day week) _____	<input type="checkbox"/>	<input type="checkbox"/>
Dental floss (___ times per day week) _____	<input type="checkbox"/>	<input type="checkbox"/>
Flouride rinse (___ times per day week) _____	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEEDING ANSWERS ARE TRUE AND CORRECT. I WILL INFORM THE OFFICE OF ANY CHANGES IN MY HEALTH OR MEDICATION LEVELS AT MY NEXT DENTAL VISIT. I WILL ALSO KEEP THE OFFICE INFORMED OF ANY CHANGES I HAVE IN MY PERSONAL INFORMATION, ADDRESS, JOB STATUS, OR INSURANCE COVERAGE.

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Signature of patient (or responsible party if patient is a minor) _____ date _____

Signature of dentist _____ date _____