

**HEALTH HISTORY**

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient's Dentist \_\_\_\_\_ Last Check-up \_\_\_\_\_

Patient's Physician \_\_\_\_\_ Last Visit \_\_\_\_\_

Physician's Address \_\_\_\_\_

Describe your general health in a few words: \_\_\_\_\_

**Please circle YES or NO to the following questions:**

- |   |     |    |                 |     |    |
|---|-----|----|-----------------|-----|----|
| 1. Do you have or have you ever had any of the following: |     |    |                 |     |    |
| Epilepsy  | YES | NO | Stroke          | YES | NO |
| Diabetes  | YES | NO | Rheumatic Fever | YES | NO |
| Heart Attach  | YES | NO | Hepatitis       | YES | NO |
| Ulcers  | YES | NO | Asthma          | YES | NO |
| Thyroid Disease   | YES | NO | Anemia          | YES | NO |
| Liver Disease   | YES | NO | Glaucoma        | YES | NO |

NOTES \_\_\_\_\_

2. Are you sensitive or allergic to any medicine? YES NO  
 If yes, what? \_\_\_\_\_
3. Are you allergic to nickel? YES NO
4. Have you been examined by a physician in the past year? YES NO
5. Have your tonsils and adenoids been removed? YES NO  
 If yes, when? \_\_\_\_\_
6. Has there been any change in your health in the last year? YES NO
7. Have you ever had surgery? YES NO
8. Have you ever been told you have heart trouble? YES NO
9. Do you get out of breath easily? YES NO
10. Do you have spells of dizziness? YES NO
11. Do you have high blood pressure? YES NO
12. Have you ever been told you have a heart murmur? YES NO
13. Do you have any blood disorders? YES NO
14. Have you ever been told you have mitral valve prolapse? YES NO
15. Do you have an artificial heart valve or joint? YES NO
16. Do you have any problems with your immune system? YES NO
17. Have you ever been tested for HIV infection? YES NO  
 If yes, was your test positive or negative? \_\_\_\_\_
18. Do you have asthma, hayfever or sinus problems? YES NO

- 19. Have you ever had lung disease? YES NO
- 20. Have you ever had lung disease? YES NO
- 21. Have you ever had fits, convulsions or seizures? YES NO
- 22. Do you have arthritis or joint trouble? YES NO
- 23. Are your joints often painfully swollen? YES NO
- 24. Have you ever had a toothache? YES NO
- 25. How often do you brush? \_\_\_\_\_
- 26. How often do you floss? \_\_\_\_\_
- 27. Do your gums bleed when you brush your teeth? YES NO
- 28. Does it hurt when you chew? YES NO
- 29. Do you have any problems with your jaws? YES NO  
If yes, explain:
- 30. Do your jaw joints click or pop? YES NO
- 31. Do you clench or grind your teeth? YES NO
- 32. Have you ever had an injury to your face, neck or jaws? YES NO  
If yes, explain:
- 33. Do you suffer from headaches, neck or back pain? YES NO
- 34. Do you have swelling or lumps in your mouth? YES NO
- 35. Do you have ear pain or pain in front of the ears? YES NO
- 36. Do your jaws feel tired after a meal? YES NO
- 37. Do you have difficulty opening or closing your mouth? YES NO
- 38. Is your sleep disturbed by pain in the head or neck region? YES NO
- 39. Are your daily activities or routine disturbed by pain in the head or neck region? YES NO
- 40. Do you consider yourself a nervous person? YES NO
- 41. Do you often feel unhappy or depressed? YES NO
- 42. Are you easily upset? YES NO
- 43. Do you smoke or use tobacco? YES NO
- 44. WOMEN: Are you pregnant? YES NO

Below is additional room to further explain any YES answers:

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List all prescription and non-prescription drugs taken or used in the past three months:

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I understand that the information I provide on this form is essential to determine my dental needs and the provision of dental treatment. I have read and I understand the above questionnaire and have answered all questions truthfully to the best of my ability. If there is any change in my/his/her health or change of medication, I will inform Dr. Robinson at the next appointment.

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Signature of Patient, Parent or Guardian Date

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W. Scott Robinson, D.D.S. Date