

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 Attack | 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 so, what? _____
3. Are you allergic to nickel? YES NO
4. Have you been examined by a physician in the last year?..... YES NO
5. Have your tonsils and adenoids been removed?..... YES NO
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

(OVER)

17. Have you ever been tested for HIV infection? YES NO
 If yes, were you positive or negative?
18. Do you have asthma, hay fever or sinus problems? YES NO
19. Have you ever had lung disease? YES NO
20. Have you ever had convulsions or seizures? YES NO
21. Do you have arthritis or joint trouble? YES NO
22. Are your joints painfully swollen? YES NO
23. Have you ever had a toothache? YES NO
24. How often do you brush? _____
25. How often do you floss? _____
26. Do your gums bleed when you brush your teeth? YES NO
27. Does it hurt when you chew? YES NO
28. Do you have any problems with your jaws? YES NO
 If yes, explain: _____

29. Do your jaw joints click or pop? YES NO
30. Do you clench or grind your teeth? YES NO
31. Have you ever had an injury to your face, neck or jaws? YES NO
 If yes please explain: _____
32. Do you suffer from headaches, neck or backaches? YES NO
33. Do you have swelling or lumps in your mouth? YES NO
34. Do you have ear pain or pain in front of your ears? YES NO
35. Do your jaws feel tired after a meal? YES NO
36. Do you have difficulty opening or closing your mouth? YES NO
37. Is your sleep disturbed by pain in the head or neck region? YES NO
38. Are your daily activities or routine disturbed by pain in the head or neck region? .. YES NO
39. Do you consider yourself a nervous person? YES NO
40. Do you often feel unhappy or depressed? YES NO
41. Are you easily upset? YES NO
42. Do you smoke or use tobacco? YES NO
43. WOMEN – Are you pregnant? YES NO

Below is additional room to explain any YES answers further:

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

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 the 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.

Signature of patient, parent or guardian _____ Date _____

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