SpringHill Dental
FAMILY AND AESTHETIC DENTISTRY

Patient Name: Birth Date: Today's Date:

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

Health History

		If yes please explain
Are you under a physician's care now?	Yes ☐ No ☐	
Have you ever been hospitalized or had a major operation?	Yes ☐ No ☐	
Have you ever had a serious head or neck injury?	Yes ☐ No ☐	
Are you taking any medications, pills, or drugs?	Yes ☐ No ☐	
Do you take, or have you taken, Phen-Fen or Redux?	Yes ☐ No ☐	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes ☐ No ☐	
Are you on a special diet?	Yes ☐ No ☐	
Do you use tobacco?	Yes ☐ No ☐	
Do you use controlled substances?	Yes ☐ No ☐	

WOMEN ONLY: Are you?
Pregnant/Trying to get pregnant? Yes ☐ No ☐ Taking oral contraceptives? Yes ☐ No ☐ Nursing? Yes ☐ No ☐

Allergy information, are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Local Anesthetics ☐ Metal ☐ Latex ☐ Sulfa drugs ☐ Local Anesthetics
☐ Other, If yes please explain:

Dental History

Reason for today's visit?	
Former Dentist?	
Date of last dental visit?	
Date of last dental exam?	
How often do you floss?	
How often do you brush?	

Dental and General Health Conditions: Check yes or no to indicate if you have had any of the following

Bad Breath	Yes ☐ No ☐	Bleeding gums	Yes ☐ No ☐	Blisters on lips or gums	Yes ☐ No ☐	Burning sensation on tongue	Yes ☐ No ☐
Chew on one side of mouth	Yes ☐ No ☐	Clicking or popping jaw	Yes ☐ No ☐	Dry mouth	Yes ☐ No ☐	Fingernail biting	Yes ☐ No ☐
Food collection between teeth	Yes ☐ No ☐	Foreign objects	Yes ☐ No ☐	Grinding teeth	Yes ☐ No ☐	Gums swollen or tender	Yes ☐ No ☐
Jaw pain or tiredness	Yes ☐ No ☐	Lip or cheek biting	Yes ☐ No ☐	Loose teeth or broken filing	Yes ☐ No ☐	Mouth breathing	Yes ☐ No ☐
Mouth pain, brushing	Yes ☐ No ☐	Orthodontic treatment	Yes ☐ No ☐	Pain around ear	Yes ☐ No ☐	Periodontal treatment	Yes ☐ No ☐
Sensitivity to cold	Yes ☐ No ☐	Sensitivity to heat	Yes ☐ No ☐	Sensitivity to sweets	Yes ☐ No ☐	Sensitivity when biting	Yes ☐ No ☐

Sores or growth in your mouth	Yes ☐ No ☐		Yes ☐ No ☐		Yes ☐ No ☐		Yes ☐ No ☐

Do you have, or have had any of the following

AIDS/HIV Positive	Yes ☐ No ☐	Cortisone Medicine	Yes ☐ No ☐	Hemophilia	Yes ☐ No ☐	Radiation Treatments	Yes ☐ No ☐
Alzheimer's Disease	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐	Hepatitis A	Yes ☐ No ☐	Recent Weight Loss	Yes ☐ No ☐
Anaphylaxis	Yes ☐ No ☐	Drug Addiction	Yes ☐ No ☐	Hepatitis B or C	Yes ☐ No ☐	Renal Dialysis	Yes ☐ No ☐
Anemia	Yes ☐ No ☐	Easily Winded	Yes ☐ No ☐	Herpes	Yes ☐ No ☐	Rheumatic Fever	Yes ☐ No ☐
Angina	Yes ☐ No ☐	Emphysema	Yes ☐ No ☐	High Blood Pressure	Yes ☐ No ☐	Rheumatism	Yes ☐ No ☐
Artificial Heart Valve	Yes ☐ No ☐	Epilepsy or Seizures	Yes ☐ No ☐	High Cholesterol	Yes ☐ No ☐	Scarlet Fever	Yes ☐ No ☐
Artificial Joint	Yes ☐ No ☐	Excessive Bleeding	Yes ☐ No ☐	Hives or Rash	Yes ☐ No ☐	Shingles	Yes ☐ No ☐
Asthma	Yes ☐ No ☐	Excessive Thirst	Yes ☐ No ☐	Hypoglycemia	Yes ☐ No ☐	Sickle Cell Disease	Yes ☐ No ☐
Blood Disease	Yes ☐ No ☐	Fainting Spells/Dizziness	Yes ☐ No ☐	Irregular Heartbeat	Yes ☐ No ☐	Sinus Trouble	Yes ☐ No ☐
Blood Transfusion	Yes ☐ No ☐	Frequent Cough	Yes ☐ No ☐	Kidney Problems	Yes ☐ No ☐	Spina Bifida	Yes ☐ No ☐
Breathing Problems	Yes ☐ No ☐	Frequent Diarrhea	Yes ☐ No ☐	Leukemia	Yes ☐ No ☐	Stomach/Intestinal Disease	Yes ☐ No ☐
Bruise Easily	Yes ☐ No ☐	Frequent Headaches	Yes ☐ No ☐	Liver Disease	Yes ☐ No ☐	Stroke	Yes ☐ No ☐
Cancer	Yes ☐ No ☐	Genital Herpes	Yes ☐ No ☐	Low Blood Pressure	Yes ☐ No ☐	Swelling of Limbs	Yes ☐ No ☐
Chemotherapy	Yes ☐ No ☐	Glaucoma	Yes ☐ No ☐	Lung Disease	Yes ☐ No ☐	Thyroid Disease	Yes ☐ No ☐
Chest Pains	Yes ☐ No ☐	Hay Fever	Yes ☐ No ☐	Mitral Valve Prolapse	Yes ☐ No ☐	Tonsillitis	Yes ☐ No ☐
Cold Sores/Fever Blisters	Yes ☐ No ☐	Heart Attack/Failure	Yes ☐ No ☐	Osteoporosis	Yes ☐ No ☐	Tuberculosis	Yes ☐ No ☐
Congenital Heart Disorder	Yes ☐ No ☐	Heart Murmur	Yes ☐ No ☐	Pain in Jaw Joints	Yes ☐ No ☐	Tumors or Growths	Yes ☐ No ☐
Convulsions	Yes ☐ No ☐	Heart Pacemaker	Yes ☐ No ☐	Parathyroid Disease	Yes ☐ No ☐	Ulcers	Yes ☐ No ☐
Yellow Jaundice	Yes ☐ No ☐	Heart Trouble/Disease	Yes ☐ No ☐	Psychiatric Care	Yes ☐ No ☐	Venereal Disease	Yes ☐ No ☐
Have you ever had any serious illness not listed?			Yes ☐ No ☐	If yes please list:			

Comments:

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, PARENT, or GUARDIAN _____ DATE _____