McOmber DENTAL
Comprehensive Dentistry and Implant Center

All information is completely confidential.

HEALTH HISTORY

Name _____ Date _____

How did you hear about us?_____

Date of last health care exam: _____What was this exam for?_____

Have you been hospitalized in the last 5 years?_____

If yes, why?_____

Please list all the names and phone numbers of the physicians who are currently providing you care (include primary care physician):

1. _____
2. _____
3. _____

For the following questions circle yes or no.

Anemia or Blood Disorder	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease	No	Yes	Joint Replacement When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor	No	Yes			
Diabetes	No	Yes	Pre-medication before dental visits	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy	No	Yes
Glaucoma	No	Yes	H.I.V. Infection/AIDS	No	Yes
Heart Disease, Heart Attack, Heart Surgery/stent	No	Yes	Venereal Disease	No	Yes

Have you been treated with Bisphosphonate (bone) drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®) If so, when did the treatment begin? When did the treatment end?	No	Yes

Please list any medications you are currently taking:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Women: Are you pregnant? No Yes
Are you a nursing mother? No Yes

Abnormal Blood Pressure? (Please circle) No Yes
Have you ever received a diagnosis of "high blood pressure"? No Yes
What is your normal blood pressure? _____

Have you had an allergic reaction to:

a. Local anesthetics ……... No Yes
b. Penicillin or other antibiotics …… No Yes
c. Aspirin, Ibuprofen or Tylenol …..…… No Yes
d. Codeine, Valium® or other sedatives…… No Yes
e. Latex or Metals…….. No Yes
f. Other (please specify)_____

DENTAL HISTORY

Hot, cold, or sweet sensitivity	No	Yes	History of orthodontic treatment	No	Yes
Mouth odor or bad taste	No	Yes	History of oral surgery	No	Yes
Pain while biting or chewing	No	Yes	Periodontal surgery	No	Yes
Cold sores, blisters or any other oral lesions	No	Yes	Bleeding or painful gums	No	Yes
Gum disease	No	Yes	Mouth breathing	No	Yes
Loose teeth or change in your bite	No	Yes	Smoking or chewing tobacco	No	Yes
Neck aches, headaches, or shoulder aches	No	Yes	Sleep Apnea or snoring	No	Yes
Grinding or clenching of teeth	No	Yes	Prominent gag reflex	No	Yes

PATIENT GOALS

What is your goal for dental treatment?_____
_____

Are you in discomfort today? If so, explain_____

Name of previous dentist:_____

Date of last dental visit:_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

_____ _____ _____
Patient (print name) *Patient signature* *Date*