DENTAL HEALTH HISTORY

Name: _____ Today's Date: _____

Major complaint or reason for today's visit: _____

Have you been seen for this condition previously? □ Yes □No Date: _____

What treatment was done? _____ Treating Dentist: _____

Do you have dental exams on a routine basis? □ Yes □No When was your last exam? _____

When did you last have dental x-rays taken? _____

Check (✓) yes or no if you have had problems with any of the following:

□Y □N	Bad Breath	□Y □N	Grinding or clenching teeth	□Y □N	Sensitivity to hot
□Y □N	Bleeding Gums	□Y □N	Loose teeth	□Y □N	Sensitivity to sweets
□Y □N	Broken filings	□Y □N	Periodontal treatment	□Y □N	Sensitivity when biting
□Y □N	Clicking or popping jaw	□Y □N	Sensitivity to cold	□Y □N	Sores or growths in mouth

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? □Y □N

Have your past dental experiences been positive? □Y □N Explain: _____

What is your level of anxiety/stress/fear of going to the dentist? □ None □ Mild□ Moderate □ Severe

Gum disease has been linked with an increased risk for many chronic diseases; thus, eliminating gum disease is extremely important to your overall health. Individuals with the following conditions are at a higher risk for developing gum disease. (Please check (✓) all of the following conditions that you have or were previously diagnosed with.)

□ Tobacco User

Tobacco users are more likely to develop gum disease which is more severe and more difficult to eradicate. Gum disease itself has recently been linked with an increased risk for heart disease. Since tobacco users are already at an increased risk for heart disease (and since gum disease only worsens that risk) it is vitally important for tobacco users to do whatever is necessary to eliminate gum disease.

□ Current tobacco user. What form?

How much per day? For how long?

□ Previous tobacco user. When did you quit?

□ Diabetic

Diabetes is a well-known risk factor for gum disease. Research is confirming that when left untreated gum disease makes it harder for you to control your blood sugar. Elimination of gum disease can improve your blood sugar control reducing your risk for the serious complications.

How are your blood sugar readings? □Good □Fair □Poor

□ Family History of Gum Disease	Some people are genetically prone to developing gum disease even if they take decent care of their mouths. Do you have a family history of gum disease? □Yes □No □Don't know
□ Stress	Stress is a well-known risk factor for gum disease. Would you consider you have a high level of stress in your life? □Yes □No Life altering events (loss of job, divorce, death in family, moving to new location, etc.) can be particularly strong factors for gum disease. Are you currently going through and life altering events?□Yes □No
□Rheumatoid Arthritis	If you have arthritisyou are at an increased risk for gum disease. Emerging research suggests thateliminating any gum disease and then keeping it at bay can lessen the crippling effectsof arthritis. Have you ever been diagnosed with Rheumatoid Arthritis?□Yes □No
□Overweight	Being overweight is now recognized as a strong risk factor for gum disease. Obesity and gum disease are both risk factors for heart disease and diabetes. Thus, if you are over your ideal weight it is vitally important for you to eliminate any gum inflammation to lower your risks for more serious health problems.

MEDICALHEALTH HISTORY

Physician's Name: _____ Phone Number: _____

Have you had any illnesses, operations or been hospitalized in the last 5 years? □Y □N

If yes, explain: _____

Check (✓) yes or no whether you have had any of the following:

□Y □N	AIDS/HIV positive	□Y □N	Epilepsy	□Y □N	Psychiatric care
□Y □N	Anaphylaxis	□Y □N	Fainting	□Y □N	Rapid weigh gain/loss
□Y □N	Anemia	□Y □N	Food allergies	□Y □N	Radiation treatment
□Y □N	Arthritis, Rheumatism	□Y □N	Glaucoma	□Y □N	Respiratory disease
□Y □N	Artificial heart valves	□Y □N	Headaches	□Y □N	Rheumatic/scarlet fever
□Y □N	Artificial joints	□Y □N	Heart murmur	□Y □N	Shingles
□Y □N	Asthma	□Y □N	Heart problems	□Y □N	Shortness of breath
□Y □N	Atopic ((allergy prone)	□Y □N	Hemophilia/ abnormal bleeding	□Y □N	Sleep apnea
□Y □N	Back problems	□Y □N	Herpes	□Y □N	Snoring
□Y □N	Blood disease/bleeding problems	□Y □N	Hepatitis	□Y □N	Stroke

☐Y ☐N	Cancer	☐Y ☐N	High blood pressure	☐Y ☐N	Surgical implant
☐Y ☐N	Chemical dependency	☐Y ☐N	Jaw pain	☐Y ☐N	Swelling of feet/ankles
☐Y ☐N	Chemotherapy	☐Y ☐N	Kidney disease or malfunction	☐Y ☐N	Thyroid disease or malfunction
☐Y ☐N	Circulatory problems	☐Y ☐N	Liver disease	☐Y ☐N	Tobacco habit
☐Y ☐N	Cortisone treatments	☐Y ☐N	Material allergies (latex, wood, metal, chemicals)	☐Y ☐N	Tonsillitis
☐Y ☐N	Cough, persistent	☐Y ☐N	Mitral valve prolapse	☐Y ☐N	Tuberculosis
☐Y ☐N	Cough up blood	☐Y ☐N	Nervous problems	☐Y ☐N	Ulcer/Colitis
☐Y ☐N	Diabetes	☐Y ☐N	Pacemaker/heart surgery	☐Y ☐N	Vertigo

☐Other:

If you are female, are you:

☐Y ☐N	Pregnant	☐Y ☐N	Nursing	☐Y ☐N	Taking birth control pills
☐Y ☐N	Peri-menopause	☐Y ☐N	Post-menopause	☐Y ☐N	Taking hormones
☐Y ☐N	Ever diagnosed with breast cancer	☐Y ☐N	Ever diagnosed with PCOS	☐Y ☐N	Ever diagnosed with osteoporosis

Are you allergic to any medications or substances? Check (✓) all that you are allergic to:

☐Aspirin/advil	☐Codeine	☐Metal
☐Acrylic	☐Latex	☐Penicillin
☐Antibiotics	☐Local anesthetics/novocaine	☐Sulfa
☐Other:		

Are you taking any medications? ☐ Yes ☐No

Do you take any blood thinners? ☐ Yes ☐No

Do you take any immunosuppressant medications? ☐ Yes ☐No

Please list any medications you are currently taking and what they are for: _____

_____

_____

_____

Are you taking any supplements? ☐ Yes ☐No

Please list any supplements you are currently taking: _____

_____

_____

AUTHORIZATION

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member if his/her staff responsible for any errors or omissions that I have made in the completion of this form. IF there is any change in my medial status, I will inform my dentist and his/her staff.

Patient or Guarantor's signature: _____ **Date:** _____

This signature on file is my authorization for the release of information necessary to process my claim.

Patient or Guarantor's signature: _____ **Date:** _____

I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

Patient or Guarantor's signature: _____ **Date:** _____

CONSENT TO SHARE INFORMATION

I consent for Healthy Roots Dentistry to share my personal information, especially with regards to my dental diagnosis and treatment, with the following people:

Name: _____

Name: _____

Name: _____

Patient or Guarantor's signature: _____ **Date:** _____

Health history form has been completed and reviewed.

Signature of Staff: _____ **Date:** _____