

Dr. Costa & Dr. Waxman's Family Dentistry Health History

Patient Name (Please Print) _____ DOB _____ DATE _____

Health conditions that you may have, or medication you may be taking, can have an important interrelationship with the dentistry that you may be receiving. Please complete thoroughly:

Do you have a PCP? List their name and date of last exam Yes No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Have you ever been diagnosed with cancer? Yes No _____

Do you use tobacco or any recreational drugs (e.g. smoke, chew, vape, etc.)? Yes No _____

Have you ever taken any bisphosphonates (e.g. Fosamax, Boniva, Actenol, Zometa, Reclast, etc.)? Yes No _____

Please list all current medications or supplements (prescription or OTC):

Women only:

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Allergies: Do you have the following allergies?

Aspirin <input type="radio"/> Yes <input type="radio"/> No	Codeine <input type="radio"/> Yes <input type="radio"/> No	Metal <input type="radio"/> Yes <input type="radio"/> No	Sedatives <input type="radio"/> Yes <input type="radio"/> No
Sulfa Drugs <input type="radio"/> Yes <input type="radio"/> No	Local Anesthetics <input type="radio"/> Yes <input type="radio"/> No	Iodine <input type="radio"/> Yes <input type="radio"/> No	Others: <input type="radio"/> Yes <input type="radio"/> No
Seasonal <input type="radio"/> Yes <input type="radio"/> No	Penicillin <input type="radio"/> Yes <input type="radio"/> No	Latex <input type="radio"/> Yes <input type="radio"/> No	_____

Health Conditions/Concerns: Do you have, or have you had, any of the following conditions?

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Developmental Disorder <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Amyotrophic Lateral Sclerosis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Emphysema/COPD <input type="radio"/> Yes <input type="radio"/> No	Multiple Sclerosis <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	Muscular Dystrophy <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Clicking/Popping of Jaw <input type="radio"/> Yes <input type="radio"/> No
Anxiety <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Parkinson's Disease <input type="radio"/> Yes <input type="radio"/> No	Jaw Locking <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Heart Attack <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Sore Neck/Shoulders <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Heart Disease <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No	Clenching/Grinding <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Heart Failure <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No	Difficulty Chewing <input type="radio"/> Yes <input type="radio"/> No
Autoimmune Disease <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No	Broken Teeth <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No	Pain Around Eyes <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hepatitis <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No	Pain in Temple Region <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/ Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No	Earache <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No	Ringling in Ears <input type="radio"/> Yes <input type="radio"/> No
Depression <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No	

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Dental History/Concerns:

Gums bleed while brushing or flossing? <input type="radio"/> Yes <input type="radio"/> No	Previously had braces? <input type="radio"/> Yes <input type="radio"/> No	Mouth habits: nail biting, Thumb sucking? <input type="radio"/> Yes <input type="radio"/> No
Sensitivity to hot/cold? <input type="radio"/> Yes <input type="radio"/> No	Is Fluoride taken in any form? <input type="radio"/> Yes <input type="radio"/> No	Prolonged bleeding post dental procedure? <input type="radio"/> Yes <input type="radio"/> No
Do you experience dry mouth? <input type="radio"/> Yes <input type="radio"/> No	Do you use an electric toothbrush? <input type="radio"/> Yes <input type="radio"/> No	Is there anything you would like to change about your smile? _____
Do you currently use a mouth guard? <input type="radio"/> Yes <input type="radio"/> No	Sores or lumps in or out of the mouth? <input type="radio"/> Yes <input type="radio"/> No	
Tooth pain? <input type="radio"/> Yes <input type="radio"/> No	Do you have dental anxiety? <input type="radio"/> Yes <input type="radio"/> No	
Are you brushing daily? How often? _____	Are you flossing? How often? _____	

Acknowledgement:

Office Use Only: ♥ Blood Pressure: _____ / _____

Pre-Med Status: Yes No

To the best of my knowledge, the above questionnaire has been answered accurately. I understand that providing incorrect information can be dangerous to my (or the patients) health. I also understand that it is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient/Guardian _____

Date _____

Signature of Dentist _____

Date _____