Russell Street Dental Associates **Health History** **PT. ID#_____**

_____ _____ _____

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	○ Yes ○ No	Codeine	○ Yes ○ No	Metal	○ Yes ○ No	Sedatives	○ Yes ○ No
Sulfa Drugs	○ Yes ○ No	Local Anesthetics	○ Yes ○ No	Iodine	○ Yes ○ No	Others:	○ Yes ○ No
Seasonal	○ Yes ○ No	Penicillin	○ Yes ○ No	Latex	○ Yes ○ No		

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

AIDS/HIV Positive	○ Yes ○ No	Developmental Disorder	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Liver Disease	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Amyotrophic Lateral Sclerosis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Emphysema/COPD	○ Yes ○ No	Multiple Sclerosis	○ Yes ○ No	Frequent Headaches	○ Yes ○ No
Anemia	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	Muscular Dystrophy	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No
Angina	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Clicking/Popping of Jaw	○ Yes ○ No
Anxiety	○ Yes ○ No	Fainting Spells/ Dizziness	○ Yes ○ No	Parkinson's Disease	○ Yes ○ No	Jaw Locking	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Heart Attack	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Sore Neck/Shoulders	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Heart Disease	○ Yes ○ No	Radiation Treatments	○ Yes ○ No	Clenching/Grinding	○ Yes ○ No
Asthma	○ Yes ○ No	Heart Failure	○ Yes ○ No	Renal Dialysis	○ Yes ○ No	Difficulty Chewing	○ Yes ○ No
Autoimmune Disease	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Shingles	○ Yes ○ No	Broken Teeth	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Hemophilia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No	Pain Around Eyes	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hepatitis	○ Yes ○ No	Sinus Trouble	○ Yes ○ No	Pain in Temple Region	○ Yes ○ No
Cold Sores/ Fever Blisters	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No	Earache	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Stroke	○ Yes ○ No	Ringing in Ears	○ Yes ○ No
Depression	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Swelling of Limbs	○ Yes ○ 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?	○ Yes ○ No	Previously had braces?	○ Yes ○ No	Mouth habits: nail biting, Thumb sucking?	○ Yes ○ No
Sensitivity to hot/cold?	○ Yes ○ No	Is Fluoride taken in any form?	○ Yes ○ No	Prolonged bleeding post dental procedure?	○ Yes ○ No
Do you experience dry mouth?	○ Yes ○ No	Do you use an electric toothbrush?	○ Yes ○ No	Is there anything you would like to change about your smile? _____	
Do you currently use a mouth guard?	○ Yes ○ No	Sores or lumps in or out of the mouth?	○ Yes ○ No		
Tooth pain?	○ Yes ○ No	Do you have dental anxiety?	○ Yes ○ No		
How often do you brush your teeth? _____		How often do you floss? _____			

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**