Maryanne B. Butler, DDS, MS
Amy M. Riffel, DDS, MS

Health History

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name_____ **Birth date**_____ **Age**_____
Why are you seeking dental treatment?_____
Have you or any member of your family been seen by us before? ( )**Yes** ( )No
If **yes**, which family member(s)? _____
Are you now under the care of a physician? ( )**Yes** ( )No
If so, what is the condition being treated?_____
Date of last ***physical*** examination_____ Physician's Name_____
Date of last ***dental*** examination _____ Date of last dental x-rays_____
Current Dentist's name_____ City/State_____

- Are you having pain or discomfort at this time? ( )**Yes** ( )No
- Do you feel nervous about having dental treatment? ( )**Yes** ( )No
- Have you ever had a bad experience in a dental office? ( )**Yes** ( )No
- Have you ever been hospitalized or had a serious illness? ( )**Yes** ( )No
  If **yes**, explain _____

- Are you **ALLERGIC** or have you ever experienced any reaction to the following?

Local anesthetics (Novocaine)	( )**Yes**	( )No	Aspirin or codeine	( )**Yes**	( )No
Barbiturates/sedatives/sleeping pills	( )**Yes**	( )No	Sulfa drugs	( )**Yes**	( )No
Penicillin/other antibiotics	( )**Yes**	( )No	Latex	( )**Yes**	( )No
Any type of metal	( )**Yes**	( )No	Other allergies_____		

- Are you **currently taking** any of the following?

Antibiotics/sulfa drugs	( )**Yes**	( )No	Tranquilizers	( )**Yes**	( )No
Blood thinners	( )**Yes**	( )No	Thyroid medicine	( )**Yes**	( )No
Insulin/other diabetes drugs	( )**Yes**	( )No	Cortisone/steroids	( )**Yes**	( )No
Blood pressure medicine	( )**Yes**	( )No	Recreational drugs	( )**Yes**	( )No
Antihistamines/allergy drugs	( )**Yes**	( )No	OTC cold medications	( )**Yes**	( )No
Heart medications (digitalis)	( )**Yes**	( )No	Nitroglycerin	( )**Yes**	( )No
Aspirin	( )**Yes**	( )No	Vitamins/herbal supplements/		
Bisphosphonate (fosamax)	( )**Yes**	( )No	"cures"	( )**Yes**	( )No

Other medications not listed above you are taking: _____

If **YES** to any of the above, list ***NAME*** of medication and DOSAGE

_____
_____
_____

- Have you ever been told of any need to pre-medicate with antibiotics for dental procedures? ( )**Yes** ( )No
- Do you currently use tobacco products? ( )**Yes** ( )No
- Have you used tobacco products in the past? ( )**Yes** ( )No
  _____Cigarettes _____Cigars _____Smokeless Tobacco
  Quantity used per day: _____Years of use: _____
- Do you use alcoholic beverages (more than 2 drinks per day)? ( )**Yes** ( )No

---

Maryanne B. Butler, DDS, MS
Amy M. Riffel, DDS, MS

- Do you ***have*** or ***have you ever had*** any of the following?

	YES	*NO*		*YES*	*NO*		*YES*	*NO*
Chest Pain	☐	☐	Shortness of Breath	☐	☐	Hives or skin rash	☐	☐
Mitral Valve Prolapse	☐	☐	Ulcers	☐	☐	Prolonged bleeding	☐	☐
Heart Disease/Attack	☐	☐	Diabetes	☐	☐	Cold Sores	☐	☐
Heart pacemaker	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Heart Problems	☐	☐	Fainting /dizzy spells	☐	☐	Steroid Treatment	☐	☐
Heart Surgery	☐	☐	Eating Disorder	☐	☐	Arthritis	☐	☐
High Blood Pressure	☐	☐	Epilepsy or seizures	☐	☐	Any type of implant	☐	☐
Heart Murmur	☐	☐	Chronic Cough	☐	☐	Sinus trouble	☐	☐
Rheumatic Fever	☐	☐	Tuberculosis (TB)	☐	☐	Birth defects	☐	☐
Congenital heart disease	☐	☐	HIV +/ARC/AIDS	☐	☐	Liver Disease	☐	☐
Hepatitis A	☐	☐	Hepatitis B	☐	☐	Hepatitis C	☐	☐
Bruise easily	☐	☐	Jaundice	☐	☐	Artificial joints	☐	☐
Thyroid Disease	☐	☐	Anemia	☐	☐	Sickle Cell Disease	☐	☐
Stroke	☐	☐	Kidney Trouble	☐	☐	Hemophilia	☐	☐
Blood transfusion	☐	☐	Any type of transplant	☐	☐	Mental Health Care	☐	☐
Asthma	☐	☐	Venereal Disease	☐	☐			

- Have you ever had or do you currently have cancer? ( )**Yes** ( )No
  If **Yes**, what type_____; chemotherapy and/or radiation? ( )**Yes** ( )No
- **Women**: Are you pregnant? ( )**Yes** ( )No Are you breastfeeding ( )**Yes** ( )No
  Are you taking birth control pills ( ) Yes ( ) No
- Do you have difficulty breathing while lying down? ( )**Yes** ( )No

- Do you ***have*** or ***have you ever experienced*** any of the following problems:

MOUTH	*YES*	*NO*	TEETH	*YES*	*NO*
Bleeding/sore gums	☐	☐	Loose teeth	☐	☐
Pain in or around your ears	☐	☐	Sensitive to hot	☐	☐
Difficulty chewing	☐	☐	Sensitive to cold	☐	☐
Difficulty opening or closing jaw	☐	☐	Sensitive to sweets	☐	☐
Unpleasant taste/bad breath	☐	☐	Sensitive to biting	☐	☐
Frequent blisters on mouth/lips	☐	☐	Food impaction	☐	☐
Burning tongue/lips	☐	☐	Clenching/grinding	☐	☐
Swelling/lumps in mouth	☐	☐	Shifting of teeth	☐	☐
Orthodontic treatment (braces)	☐	☐	Change in bite	☐	☐
Biting cheeks/lips	☐	☐	Dentures or Partials	☐	☐
Clicking/popping jaw	☐	☐			

- Have you ever had oral surgery, periodontal surgery or treatment? ( )**Yes** ( )No
  If **Yes**, explain/when:_____
- Is there anything you dislike about your smile?_____
- Do you use the following?
  Brush ( )**Yes** ( )No How often do you brush:_____
  Dental Floss ( )**Yes** ( )No How often do you floss:_____
  Fluoride rinse ( )**Yes** ( )No Is your brush: ____ Soft ____ Medium ____ Hard ____ Electric
  Other_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

X_____
Signature of patient or guardian