Health and Dental History

Patient Name:_____
First MI Last

Birth Date:_____

Parent/Guardian (if applicable):_____
Patient Age:_____ ____Male ____Female

___ Married ___Single ___Child ___Other

Pharmacy Information

Pharmacy Name:_____

Pharmacy Address:_____

Pharmacy Phone Number:_____

Phone Numbers:

Home:_____ Work:_____

Cell:_____

Email Address: _____

HomeAddress:_____

City: _____ State: _____ Zip: _____

Health Information

Date of Last Dental Visit: _____

Reason for Visit:_____

Are You Currently in Any Dental Pain Right Now? Yes No
If yes, Please explain_____

Have You Ever Had Any Complications During or Following Dental Treatment? Yes No
If Yes, Please Explain:_____

Are You Unhappy About Your Smile? Yes No
If Yes, Please Explain:_____

Have You Had Braces? Yes No
If Yes, Please List Orthodontist's Name and Number:_____

Are You Aware of Having an Allergic Reaction to Any Medication or Substance? Yes No
If Yes, Please Explain:_____

Do You Smoke or Drink? Yes No
If Yes, Please Explain:_____

Are You Taking/Using any Recreational Drugs? Yes No
If Yes, Please Explain:_____

Have You Been Admitted to the Hospital or Needed Emergency Care During The Past Two Years? Yes No
If Yes, Please Explain:_____

Are You Taking Birth Control Pills? Yes No
If Yes, Please Provide Name:_____
Are you Pregnant, or Trying to Become Pregnant? Yes No

If Yes, How Many Weeks?_____

When is Your Due Date?_____

Are you Nursing? Yes No
Are You now Under The Care of a Physician? Yes No

If Yes, Please Explain:_____

Are You Taking Any Medications? Yes No

If Yes, Please List Name And Dose:_____

PLEASE LIST ANY MEDICATION YOU MAY BE CURRENTLY TAKING

MEDICATION	DOSAGE	HOW OFTEN	ROUTE (ORAL/INJECTION)	WHAT IS MEDICATION TAKEN FOR?

TEXAS CHOICE DENTAL

MEDICAL HISTORY CONTINUED

HAVE YOU EVER EXPERIENCED OR HAD ANY OF THE FOLLOWING?
PLEASE MARK YES OR NO TO EACH ITEM.

AIDS/HIV	□Yes □No	Hepatitis A B C or D	□Yes □No
Allergies	□Yes □No	Herpes	□Yes □No
Anemia	□Yes □No	High Blood Pressure	□Yes □No
Arthritis/Rheumatism	□Yes □No	Hives/Rash	□Yes □No
Artificial Joints	□Yes □No	Insomnia/Frequent Waking	□Yes □No
Artificial Heart Valve	□Yes □No	Jaundice	□Yes □No
Asthma	□Yes □No	Kidney Disease	□Yes □No
Autism	□Yes □No	Liver Disease	□Yes □No
Back Problems	□Yes □No	Mental Illness	□Yes □No
Bell's Palsy	□Yes □No	Multiple Sclerosis	□Yes □No
Bladder Disease/Problems	□Yes □No	Nervous Problems	□Yes □No
Bleeding Problems	□Yes □No	Prosthetic Heart Valve	□Yes □No
Blood Transfusions	□Yes □No	Psychiatric Care	□Yes □No
Bruise Easily	□Yes □No	Radiation Treatment	□Yes □No
Cancer	□Yes □No	Respiratory Problems	□Yes □No
Circulatory Problems	□Yes □No	Rheumatic Fever	□Yes □No
Chemotherapy	□Yes □No	Ringing of Ears	□Yes □No
Chest Pain	□Yes □No	Sexually Transmitted Disease	□Yes □No
Crohn's Disease	□Yes □No	Shingles	□Yes □No
Congested Ears	□Yes □No	Sickle Cell Disease	□Yes □No
COPD	□Yes □No	Sinus Problems	□Yes □No
Diabetes	□Yes □No	Skin Rash/Disease	□Yes □No
Dizziness or Fainting	□Yes □No	Stomach Problems	□Yes □No
Down Syndrome	□Yes □No	Stroke	□Yes □No
Epilepsy	□Yes □No	Surgeries	□Yes □No
Fibromyalgia	□Yes □No	Swelling of the Limbs	□Yes □No
Glaucoma	□Yes □No	Thyroid Problems	□Yes □No
Gout	□Yes □No	Tingling in Arms/Fingers	□Yes □No
Headaches	□Yes □No	Tuberculosis	□Yes □No
Heart Attack	□Yes □No	Tumor or Growths	□Yes □No
Heart Murmur	□Yes □No	Ulcers	□Yes □No
Heart Pacemaker	□Yes □No	Weight Loss/Gain	□Yes □No

Do you have or have you had any disease, condition or problem not listed? Yes No

If Yes, Please Explain:_____

Do any of the Following Dental Concerns Apply to you?

Bad Breath	□Yes □No
Bleeding Gums	□Yes □No
Blisters on Lips or Mouth	□Yes □No
Burning Sensation on Tongue	□Yes □No
Clicking or Popping Jaw and or swollen/tender	□Yes □No
Clenching or Grinding of Your Teeth	□Yes □No
Dry Mouth	□Yes □No
Food Collecting/Packing Between Teeth	□Yes □No
Lip or Cheek Biting	□Yes □No
Loose or Broken Teeth	□Yes □No
Loose or Broken Fillings/Crowns	□Yes □No
Missing Teeth	□Yes □No
Sensitivity to Pressure or Other: (cold, heat, sweets)	□Yes □No
Stained/Darker Than Normal Teeth	□Yes □No
Spaces/Gaps Between Teeth	□Yes □No
Tooth Ache(s)	□Yes □No
Other Dental Concerns (Please List):	□Yes □No

I have answered all the questions to the best of my knowledge. Should further information be needed, I grant permission to ask my respective healthcare providers or agencies, who may release information to you. I will notify the dentist of any changes in my heath or medication.

_____ _____

Patient's (or legal guardian's) signature Date