Health History Form

Name:

DR. BRAD MITCHELL, DDS

In case of emergency who should be notified? _____ **Date:** ___/___/_____ **Phone:** (___)___-_____

Medical History

Your current physical health is: ☐ Good ☐ Fair ☐ Poor
Are you currently under the care of a physician? ☐ Y ☐ N
Please explain:_____
Do you smoke or use tobacco in any form? ☐ Y ☐ N
Have you had metal rods, pins, or implants in any part of your body? ☐ Y ☐ N
Are you taking any prescription/over-the-counter drugs? ☐ Y ☐ N
Please list:_____
_____
Have you ever taken Fosamax, Actonel or other bisphosphonates? ☐ Y ☐ N
Have you been treated with IV Zometa or Aredia for Paget's disease or cancer? ☐ Y ☐ N

For Women:
Are you using a prescribed method of birth control? ☐ Y ☐ N
Are you pregnant? ☐ Y ☐ N
Are you nursing? ☐ Y ☐ N

Do you have, or have you ever had any of the following? Please check all that apply.

Abnormal bleeding/hemophilia	☐	Herpes	☐
AIDS	☐	High blood pressure	☐
Alcohol/drug abuse	☐	HIV	☐
Anemia	☐	Hospitalized for any reason	☐
Arthritis	☐	Kidney problems	☐
Artificial joints/valves	☐	Liver disease	☐
Asthma	☐	Low blood pressure	☐
Blood transfusion	☐	Lupus	☐
Cancer/chemotherapy	☐	Mitral valve prolapse	☐
Colitis	☐	Pacemaker	☐
Congenital heart defect	☐	Psychiatric Problems	☐
Diabetes	☐	Radiation treatment	☐
Difficulty breathing	☐	Rheumatic/Scarlett Fever	☐
Emphysema	☐	Seizures	☐
Epilepsy	☐	Shingles	☐
Fainting Spells	☐	Sickle Cell Disease/Traits	☐
Frequent headaches	☐	Sinus Problems	☐
Glaucoma	☐	Stroke	☐
Hay fever	☐	Thyroid problems	☐
Heart attack/surgery	☐	Tuberculosis	☐
Heart Murmur	☐	Ulcers	☐
Hepatitis	☐	Venereal disease	☐

Please list any serious medical conditions you have experienced:

Are you allergic to any of the following?
Aspirin ☐ Erythromycin ☐ Penicillin ☐
Codeine ☐ Jewelry/metals ☐ Tetracycline ☐
Dental Anesthetics ☐ Latex ☐ Other ☐
List:_____

Dental History

Why have you come to the dentist today?_____
_____
Are you currently in pain? ☐ Y ☐ N
Do you require antibiotics before dental treatment? ☐ Y ☐ N
Your current dental health is: ☐ **Good** ☐ **Fair** ☐ **Poor**
Have you ever had a serious or difficult problem associated with any previous dental work? ☐ Y ☐ N
Do you floss daily? ☐ Y ☐ N Brush Daily? ☐ Y ☐ N
Have you ever had gum treatment? ☐ Y ☐ N
Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)? ☐ Y ☐ N
Are your teeth sensitive to heat, cold, or other? ☐ Y ☐ N
Do you have any loose teeth? ☐ Y ☐ N
Do you still have wisdom teeth? ☐ Y ☐ N
Would you like fresher breath? ☐ Y ☐ N

Would you like whiter teeth? ☐ Y ☐ N
Are you happy with the way your smile looks? ☐ Y ☐ N
If not, what would you change?_____
_____
_____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the office of Dr. Brad Mitchell of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature_____Date_____

OFFICE USE ONLY:
I verbally reviewed the medical/dental information with the patient named herein. _____ Date_____

Print