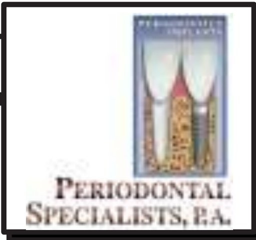

HEALTH HISTORY

11401 Nall Avenue, Leawood, KS 66211 phone: (913) 663–4867 fax: (913) 663–3667
411 Nichols Rd., Suite 236, Kansas City, MO 64112 phone: (816) 753–0202 fax: (816) 753–0253
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Correct answers to the following questions will allow the doctor to treat you on a more individual basis, providing the care appropriate for your particular needs. The medical history is one of the most important pieces of information used by the doctor in diagnosing and treating any of your problems.

Name:______________________ Date of Birth:______________ Age: __________
Who is the general dentist you normally see? ______________________

Please answer each question. Check yes or no. If in doubt, leave blank.

Question	YES	NO
1. Are you in good health now?		
2. Are you under the care of a physician?		
If so, what is the condition being treated? ______________		
3. Physician's Name:______________ Phone: __________		
4. Have you ever been hospitalized or had a serious illness?		
If yes, explain: ______________		
5. Have you ever had excessive bleeding following an extraction?		
Do cuts take longer to heal now than before?		
6. (Women) Are you pregnant? If so, give due date		
7. (Women) Do you use birth control pills?		
8. Do you use tobacco in any form: If yes, how much?		
9. Do you use alcoholic beverages (more than 2 drinks per day)?		

10. Do you have or have you had any of the following?

Condition	YES	NO
GENERAL		
Tire easily, weakness		
Marked weight change		
SKIN		
Eruptions (rash) hives		
Change in skin color		
EYES		
Visual change		
Glaucoma		
EARS		
Loss of hearing		
NOSE		
Frequent nosebleeds		
Sinus problems		
THROAT		
Soreness/hoarseness		
NERVOUS SYSTEM		
Stroke		
Headaches		
Convulsions/epilepsy		
Dizziness/fainting		
Psychiatric treatment		
RESPIRATORY		
Tuberculosis		
Emphysema		
Asthma		
Persistent cough		
Cough up bloody sputum		
Shortness of breath		
Difficulty breathing while lying down		
ENDOCRINE		
Diabetes		
Family history of diabetes		
Thyroid condition/goiter		
Other ______________		

Condition	YES	NO
HEART/BLOOD VESSELS		
Rheumatic fever		
Heart murmur		
Prolapsed mitral valve		
Heart attack/trouble		
Swelling of ankles		
High blood pressure		
Low blood pressure		
Congenital heart disease		
Artificial heart valve		
Pacemaker		
Heart surgery		
Have taken Fen-Phen		
Other ______________		
BONE/MUSCLES		
Arthritis/rheumatism		
Artificial joints		
DIGESTIVE SYSTEM		
Hepatitis		
Jaundice		
Ulcers		
URINARY		
Kidney disease		
Increase in frequency of urination (night)		
Venereal disease		
BLOOD		
Bruise easily		
Hemophilia		
HIV positive		
ARC / AIDS		
OTHER		
Radiation therapy		
Cancer		
Other ______________		
Other ______________		

I received the Notice of Privacy Practices.

Signature ______________________ Date __________

11. Are you ALLERGIC or have you experienced any reaction to the following?

	YES	NO
Penicillin		
Sulfa drugs		
Other antibiotics		
Aspirin		
Local anesthetics (e.g. novocaine)		
Codeine		
Other drug allergies		

12. Are you taking any of the following types of medications?

	YES	NO
Antibiotics/sulfa drugs		
Blood thinners		
Blood pressure medication		
Thyroid medication		
Cortisone/steroids		
Tranquilizers		
Insulin/other diabetes drugs		
Digitalis/other heart medications		
Nitroglycerin		
Aspirin		
Recreational drugs		
Other medications		

PLEASE LIST ANY AND ALL MEDICATIONS AND THEIR DOSAGES PER DAY THAT YOU ARE CURRENTLY TAKING:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

13. When was your last medical physical? ______________________________
14. Please list any surgeries you have had: ______________________________

____

15. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain: ______________________________

____

16. Have you ever had any serious trouble associated with previous dental treatment? ______________________________
17. Are you currently experiencing pain in your mouth? ______________________________
18. Does dental treatment make you nervous? No ________ Slightly ________ Moderately ________ Extremely ________
19. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ______________________________
If so, when? ______________________________
20. What treatments have you had? ______________________________
21. Do you have or have you had any of the following?

	YES	NO
Bleeding or sore gums		
Unpleasant taste/bad breath		
Orthodontic treatment (braces)		
Clicking/popping jaw		
Difficulty opening or closing jaw		
Loose teeth		
Teeth sensitive to hot		
Teeth sensitive to cold		
Teeth sensitive to sweets		
Teeth sensitive to biting		
Food impaction		
Clenching/grinding		
Shifting of teeth		

22. How often do you get your teeth cleaned? ______________________________
23. When were your teeth last cleaned? ______________________________
24. Which of the following do you use at least on a daily basis?

	YES	NO
Manual brush		
Electric brush		
Dental floss		
Fluoride rinse		
Toothpicks		

Other: ______________________________

25. How often do you brush a day? ______________________________
26. The brush I use is: Soft ______ Medium ______ Hard ______________________________

I hereby grant permission to the staff of this office for the administration of such medications and anesthetics and the performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care. I also grant permission to share information about myself to my referring dentist, other involved parties and my insurance company. The medical and dental information as answered on this form is correct to the best of my knowledge. I will notify this office if there are any changes in my Medical or Dental history. Payment is required at the time of service. We provide the use of the services of MasterCard, Visa, Amercan Express, and Discover for patients not able to pay at the time of service by check or cash.

Signature______________________________ Date ______________________________