CONFIDENTIAL HEALTH HISTORY

Patient Name: ______________________________ Date of Birth: ____________________

I. CHECK APPROPRIATE ANSWER *(Leave blank if you do not understand the question)*

☐ Yes ☐ No Is your general health good? If **NO**, please explain: ______________________________

____

☐ Yes ☐ No Has there been a change in your health within the last year? If **YES**, please explain: ____________

____

☐ Yes ☐ No Have you gone to the hospital or emergency room or had a serious illness in the last three years? If **YES**, please explain: ______________________________

____

☐ Yes ☐ No Are you being treated by a physician now? If **YES**, please explain: ______________________________

____

Date of last medical exam:____________________

☐ Yes ☐ No Have you had problems with prior dental treatment? If **YES**, please explain: ____________

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Date of last dental exam:__________ Name of last treating dentist: ____________________

☐ Yes ☐ No Are you in pain now? If **YES**, please explain: ______________________________

II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? *(Please check Yes or No for each)*

☐ Yes ☐ No Chest pain (angina)
☐ Yes ☐ No Fainting spells
☐ Yes ☐ No Recent significant weight loss
☐ Yes ☐ No Fever
☐ Yes ☐ No Night sweats
☐ Yes ☐ No Persistent cough
☐ Yes ☐ No Coughing up blood
☐ Yes ☐ No Bleeding problems
☐ Yes ☐ No Blood in urine
☐ Yes ☐ No Blood in stools
☐ Yes ☐ No Diarrhea or constipation
☐ Yes ☐ No Frequent urination
☐ Yes ☐ No Difficulty urinating
☐ Yes ☐ No Ringing in ears
☐ Yes ☐ No Headaches
☐ Yes ☐ No Dizziness
☐ Yes ☐ No Blurred vision
☐ Yes ☐ No Bruise easily
☐ Yes ☐ No Frequent vomiting
☐ Yes ☐ No Jaundice
☐ Yes ☐ No Dry mouth
☐ Yes ☐ No Excessive thirst
☐ Yes ☐ No Difficulty swallowing
☐ Yes ☐ No Swollen ankles
☐ Yes ☐ No Joint pain or stiffness
☐ Yes ☐ No Shortness of breath
☐ Yes ☐ No Sinus problems

III. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? *(Please check Yes or No for each)*

☐ Yes ☐ No Heart disease
☐ Yes ☐ No Family history of heart disease
☐ Yes ☐ No Heart attack
☐ Yes ☐ No Artificial joint
☐ Yes ☐ No Stomach problems—ulcers
☐ Yes ☐ No Heart defects
☐ Yes ☐ No Heart murmurs
☐ Yes ☐ No Rheumatic fever
☐ Yes ☐ No Skin disease
☐ Yes ☐ No Hardening of arteries
☐ Yes ☐ No High blood pressure
☐ Yes ☐ No Seizures
☐ Yes ☐ No Cosmetic surgery
☐ Yes ☐ No AIDS/HIV
☐ Yes ☐ No Surgeries
☐ Yes ☐ No Hospitalization
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Family history of diabetes
☐ Yes ☐ No Tumors or cancer
☐ Yes ☐ No Chemotherapy
☐ Yes ☐ No Radiation
☐ Yes ☐ No Arthritis, rheumatism
☐ Yes ☐ No Emphysema or other lung disease
☐ Yes ☐ No Kidney or bladder disease
☐ Yes ☐ No Stroke
☐ Yes ☐ No Eating disorders
☐ Yes ☐ No Psychiatric care
☐ Yes ☐ No Osteoporosis
☐ Yes ☐ No Thyroid disease
☐ Yes ☐ No Asthma
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No Sexually transmitted disease
☐ Yes ☐ No Herpes
☐ Yes ☐ No Canker or cold sores
☐ Yes ☐ No Anemia
☐ Yes ☐ No Liver disease
☐ Yes ☐ No Eye disease
☐ Yes ☐ No Transplants
☐ Yes ☐ No Tuberculosis

Other: ____________________

____

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?

(Please check Yes or No for each)

☐ Yes ☐ No Aspirin
☐ Yes ☐ No Penicillin or other antibiotics
☐ Yes ☐ No Nitrous oxide
☐ Yes ☐ No Valium or other sedatives
☐ Yes ☐ No Latex
☐ Yes ☐ No Local anesthetic
☐ Yes ☐ No Codeine or other narcotics
☐ Yes ☐ No Food
☐ Yes ☐ No Metal

Other: ______________________________

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?

(Please check Yes or No for each)

☐ Yes ☐ No Recreational drugs
☐ Yes ☐ No Over-the-counter medicines
☐ Yes ☐ No Weight loss medications
☐ Yes ☐ No Anti-Depressants
☐ Yes ☐ No Tobacco in any form
☐ Yes ☐ No Alcohol
☐ Yes ☐ No Cannabis in any form
☐ Yes ☐ No Herbal Supplements
☐ Yes ☐ No Antibiotics
☐ Yes ☐ No Supplements
☐ Yes ☐ No Aspirin
☐ Yes ☐ No Bisphosphonate (Fosamax)

Please list all medications or supplements that you take regularly: ______________________________

____

____

VI. WOMEN ONLY *(Please check Yes or No for each)*

☐ Yes ☐ No Are you or could you be pregnant? If **YES**, what month?______________________

☐ Yes ☐ No Are you nursing?

☐ Yes ☐ No Are you taking birth control pills?

VII. ALL PATIENTS *(Please check Yes or No for each)*

☐ Yes ☐ No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If YES, please explain: ______________________________

☐ Yes ☐ No Have you ever been pre-medicated for dental treatment? If **YES**, why? ______________________________

☐ Yes ☐ No Is there any issue or condition that you would like to discuss with the dentist in private?

VIII. DENTAL HISTORY *(Please select one box on each line)*

☐ My mouth is very comfortable ☐ My mouth is moderately comfortable ☐ My mouth is uncomfortable

☐ My smile is excellent ☐ I would like to change my smile ☐ I am unconcerned about my smile

☐ I will do whatever I must to keep my teeth ☐ I want to keep my teeth but only within a certain budget of time and money

☐ I've done the dentistry recommended to me ☐ I've NOT done dentistry recommended to me ☐ Never been recommended

My dental health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Why have you made this appointment? ______________________________

____

____

IX. SLEEP *Please place a check mark next to your condition, using Epworth's 0-3 Sleepiness Scale, during the following activities*

0 = Would never doze 1 = Slight chance of dozing 2 = Moderate chance of dozing 3 = High chance of dozing

1. Sitting and reading	☐ 0	☐ 1	☐ 2	☐ 3
2. Watching television	☐ 0	☐ 1	☐ 2	☐ 3
3. Sitting inactively in a public place	☐ 0	☐ 1	☐ 2	☐ 3
4. As a passenger in a car for an hour without a break	☐ 0	☐ 1	☐ 2	☐ 3
5. Lying down to rest in the afternoon	☐ 0	☐ 1	☐ 2	☐ 3
6. Sitting and talking to someone	☐ 0	☐ 1	☐ 2	☐ 3
7. Sitting quietly after lunch w/o alcohol	☐ 0	☐ 1	☐ 2	☐ 3
8. Driving a car stopped in traffic or at a stop light	☐ 0	☐ 1	☐ 2	☐ 3
9. Have you ever been told you snore?	☐ Yes	☐ No		
10. Do you wake up tired or fatigued?	☐ Yes	☐ No		
11. Do you have morning tension / migraine headaches	☐ Yes	☐ No		
12. Have you been diagnosed with:	☐ Chronic Fatigue Syndrome			
	☐ Irritable Bowel Syndrome			
	☐ Fibromyalgia			
	☐ Temporomandibular Syndrome			

13. Any additional comments that may be helpful? ______________________________

____

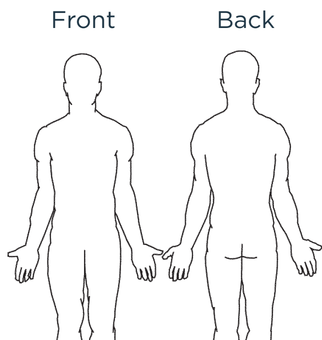
X. TMJ *If your consultation visit is concerning TMJ or TMD concerns please complete the following.*

I am experiencing:

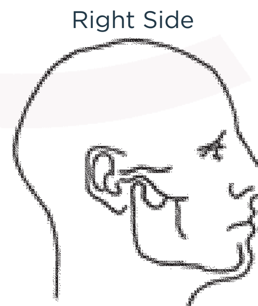
☐ Headaches	☐ Hearing changes	☐ Muscle Spasms	☐ Difficulty Eating
☐ Neckaches	☐ Ringing Ears	☐ Jaw Pain	☐ Dizziness
☐ Shoulder Pain	☐ Ear/Sinus Congestion	☐ Jaw noises	☐ Swelling
☐ Throat Pain	☐ Ear/Sinus Pain	☐ Jaw Locking	Other:____________
☐ Back Pain	☐ Visual Symptoms	☐ Fatigue	____________
☐ Ear Pain	☐ Eye Pain	☐ Difficulty Sleeping	____________

On these figures please outline where your pain is.

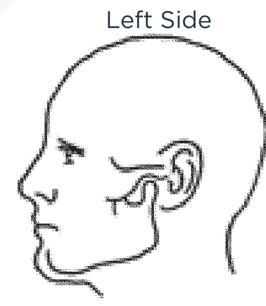
Front Back



Right Side



Left Side



Does your jaw make noise? ☐ Yes ☐ No ☐ Not now but it used to

When? ______________________________

Has your jaw ever locked open? ☐ Yes ☐ No Has it ever locked closed? ☐ Yes ☐ No

Do you ☐ clench or ☐ grind your teeth? ☐ Yes ☐ No When? ☐ Night ☐ Day

Do you have sore or sensitive teeth? ☐ Yes ☐ No Where? ______________________________

Can you remember any injury to your jaw? ☐ Yes ☐ No If yes, describe ______________________________

____

Have you ever had general anesthesia (for surgery)? ☐ Yes ☐ No When? ______________________________

If this injury is due to an accident is there (or will there be) a legal case involved? ☐ Yes ☐ No

Do you take medication for the pain? ☐ Yes ☐ No Name of medication ______________________________

Do you take medication for relaxation? ☐ Yes ☐ No Name of medication ______________________________

Have you had treatment for your pain? ☐ Yes ☐ No

If Yes, what kind? ☐ Bite Splint ☐ Medication ☐ Physical Therapy

☐ Surgery ☐ Orthodontics

☐ Counseling ☐ Occlusal (Bite) Adjustment

☐ Other: ______________________________

What else do you want Dr. Ryan to know? ______________________________

____

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize Dr. Ryan to contact my physician. ☐ Yes ☐ No

Physician's Name: ______________________________ Phone Number: ______________________________

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

______________________________ ______________ ______________________________ ______________

Signature (Parent or Guardian if a minor) *Date* *Signature of Dentist* *Date*