



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: _____

Date of last dental exam: _____ Name of last treating dentist: _____

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

II. ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING? (Please check Yes or No for each)

- | | | |
|---|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No Blood in urine | <input type="checkbox"/> Yes <input type="checkbox"/> No Dry mouth |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chest pain (angina) | <input type="checkbox"/> Yes <input type="checkbox"/> No Blood in stools | <input type="checkbox"/> Yes <input type="checkbox"/> No Excessive thirst |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Fainting spells | <input type="checkbox"/> Yes <input type="checkbox"/> No Diarrhea or constipation | <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty swallowing |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Recent significant weight loss | <input type="checkbox"/> Yes <input type="checkbox"/> No Ringing in ears | <input type="checkbox"/> Yes <input type="checkbox"/> No Swollen ankles |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Night sweats | <input type="checkbox"/> Yes <input type="checkbox"/> No Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No Joint pain or stiffness |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Persistent cough | <input type="checkbox"/> Yes <input type="checkbox"/> No Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of breath |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Coughing up blood | <input type="checkbox"/> Yes <input type="checkbox"/> No Blurred vision | <input type="checkbox"/> Yes <input type="checkbox"/> No Sinus problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent vomiting | <input type="checkbox"/> Yes <input type="checkbox"/> No Seasonal allergies |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bruise easily | <input type="checkbox"/> Yes <input type="checkbox"/> No Jaundice | |

III. DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING? (Please check Yes or No for each)

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



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

(Please check Yes or No for each)

- | | | |
|--|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Aspirin | <input type="checkbox"/> Yes <input type="checkbox"/> No Valium or other sedatives | <input type="checkbox"/> Yes <input type="checkbox"/> No Codeine or other narcotics |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Penicillin or other antibiotics | <input type="checkbox"/> Yes <input type="checkbox"/> No Latex | <input type="checkbox"/> Yes <input type="checkbox"/> No Food |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Nitrous oxide | <input type="checkbox"/> Yes <input type="checkbox"/> No Local anesthetic | <input type="checkbox"/> Yes <input type="checkbox"/> 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)

- | | | |
|---|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Recreational drugs | <input type="checkbox"/> Yes <input type="checkbox"/> No Tobacco in any form | <input type="checkbox"/> Yes <input type="checkbox"/> No Antibiotics |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Over-the-counter medicines | <input type="checkbox"/> Yes <input type="checkbox"/> No Alcohol | <input type="checkbox"/> Yes <input type="checkbox"/> No Supplements |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Weight loss medications | <input type="checkbox"/> Yes <input type="checkbox"/> No Cannabis in any form | <input type="checkbox"/> Yes <input type="checkbox"/> No Aspirin |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anti-Depressants | <input type="checkbox"/> Yes <input type="checkbox"/> No Herbal Supplements | <input type="checkbox"/> Yes <input type="checkbox"/> 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

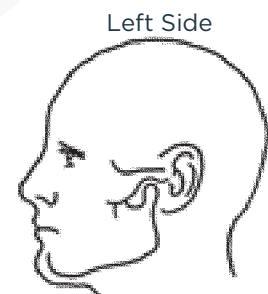
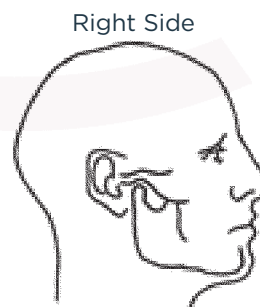
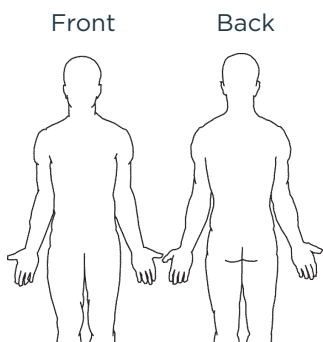
13. Any additional comments that may be helpful? _____

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

I am experiencing:

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

On these figures please outline where your pain is.





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