Silver Spring
DENTAL ARTS

HEALTH HISTORY

Today's Date: _____

Name: _____ Date of Birth: _____

Email _____

(to be used only for dental/health related purposes)

PATIENT DENTAL HISTORY

Reason for today's visit _____ Date of last dental visit _____

Former Dentist _____ Date last dental X-rays _____

Check [X] if you have had problems with any of the following:

[ ] bad breath	[ ] periodontal treatment	[ ] bleeding gums	[ ] sensitivity to hot
[ ] loose teeth	[ ] broken teeth	[ ] broken fillings	[ ] sensitivity to cold
[ ] jaw pop/click	[ ] food between teeth	[ ] grinding teeth	[ ] sensitivity to sweets
[ ] jaw pain	[ ] sores in mouth	[ ] growths in mouth	[ ] sensitivity to biting
[ ] swelling	[ ] tooth ache	[ ] pain at night	[ ] _____

How often do you brush? _____ Floss? _____

Other concerns about your smile? _____

PATIENT MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you had any serious illnesses? [ ]yes [ ]no If yes, describe _____

Have you had any surgeries/operations? [ ]yes [ ]no If yes, describe _____

WOMEN: Pregnant? [ ]yes [ ]no (Due date _____) Nursing? [ ]yes [ ]no Birth control pills? [ ]yes [ ]no

Have you ever taken any of the drugs referred to as "fen-phen"? These include Ionimin, Adipex, Fastin (phenteramine), Pondimin (fenfluramine) and/or Redux (dexfenfluramine)? [ ]yes [ ]no

Check [X] if you have or have had any of the following:

[ ] allergies	[ ] cough, persistent	[ ] hepatitis	[ ] seizures
[ ] anemia	[ ] cough up blood	[ ] high blood pressure	[ ] scarlet fever
[ ] arthritis, rheumatism	[ ] diabetes	[ ] HIV/AIDS	[ ] shortness of breath
[ ] artificial heart valve	[ ] diet, special/restricted	[ ] high cholesterol	[ ] sinus problems
[ ] artificial joint	[ ] drug/alcohol problem	[ ] jaundice	[ ] skin rash
[ ] asthma	[ ] emphysema	[ ] kidney problem	[ ] stent, cardiac
[ ] back problems	[ ] epilepsy	[ ] latex sensitivity	[ ] stomach/GI problem
[ ] blood disease/hemophilia	[ ] fainting/dizziness	[ ] liver problem	[ ] stroke
[ ] blood transfusion	[ ] glaucoma	[ ] low blood pressure	[ ] swollen feet/ankles
[ ] bruise easily	[ ] hay fever	[ ] migraines	[ ] thyroid problem
[ ] cancer	[ ] headaches	[ ] mitral valve prolapse	[ ] TIA/mini-stroke
[ ] canker sore/fever blister	[ ] heart attack	[ ] neurological problem	[ ] tobacco habit
[ ] chemotherapy	[ ] heart disease	[ ] osteoporosis	[ ] tonsillitis
[ ] chest pain	[ ] heart murmur	[ ] pacemaker	[ ] tuberculosis
[ ] circulatory problems	[ ] heart pacemaker	[ ] radiation treatment	[ ] tumor
[ ] cortisone shots	[ ] heart problems	[ ] rheumatic fever	[ ] ulcer
[ ] blood thinners	[ ] prednisone/steroids	[ ] take antibiotic before receiving dental treatment	

Any other not listed above _____

List current medicines: _____

_____

_____

List allergies to medicines: _____

Signature Patient/Parent/Guardian _____ Date _____

Printed Name of above person _____ Relation to pt _____

Signature Mellanie Thompson, DDS _____ Date _____