Dr. Kristen Gibson Dr. Clara Felker

HEALTH HISTORY CONDITIONS – PLEASE CHECK ALL THAT APPLY

Name: _____ **D.O.B**: _____

Asthma/Allergy :
Asthma /Use inhaler
Hay fever
Use Inhaler
Allergies _____
_____

Blood Problems :
Blood Disease
High Blood Pressure
Low Blood Pressure
Easily Bruising
Previous Blood Transfusion
Excessive Bleeding
Hemophilia
Anemia

Heart Problems :
Angina/Chest Pain
Rheumatic Fever
Congenital Heart Defect
Heart Murmur
Heart Disease
Shortness of Breath
Taking Heart Medication (List Below in Medication Box)
Artificial Heart Valve
Heart Surgery – Date: _____
Pacemaker
Mitral Valve Prolapse/ Heart Valve Problem
Stroke – Year: _____
Heart Attack – Year: _____

Allergic Reactions To :
Latex Tetracycline Allergy Erythromycin Allergy
Allergies to medication/Antibiotics: Y or N
Please list : _____
Allergic to Codeine, Demerol or Other Narcotics? Y or N
Sulfa Drug Allergy
Have you had an allergic reaction to any dental anesthetic/products? Y or N
Reaction to metals

Women :
Reached Menopause
Pregnant – How many weeks?
_____
Nursing
Taking Contraceptives/ Hormones? Y or N

Joint or Bone :
Do you have Artificial Joints? Y or N
If yes please note which joint and year of surgery: _____
_____
Arthritis
Osteoporosis
Bisphosophonate

Other Health Conditions :

Acid Reflux	Drug/Alcohol Abuse	Frequent Mouth Sores	Nervous Disorders	Swollen Glands	Chronic Diarrhea
Difficulty Breathing	Dry Mouth	Glaucoma	Persistent Cough	Tuberculosis	
Cancer	Emphysema	Growths	Radiation Treatment	Tumers	
Colitis	Epilepsy	Hospitalized	Respiratory Problems	Tobacco/Vape Use	
Diabetes	Fainting	Kidney Problems	Shingles	Ulcers	
Dizziness	Frequent Headaches	Mental Health Disorders	Sinus Problems	Other - _____	

Please list current medications :

Other Health Notes :

Patient Signature : _____ **Date:** _____

Previous Dentist: _____ **Date of last dental visit:** _____

May we request x-rays? YES or NO

Have you ever had complications during dental treatment YES or NO

Have you been admitted to a hospital or needed emergency care in the past 2 years? YES or NO

Are you under the care of a physician? YES or NO

Do you have any health problems that need further clarification? YES or NO

Name of physician:

_____

Do you have or have you ever had any of the following:

- Bleeding, sore gums
- Unpleasant taste or bad breath
- Burning tongue or lips
- Frequent blisters n lips or in mouth
- Swelling or lumps in mouth
- Clicking or popping of jaw
- Loose teeth
- Sensitive to hot
- Sensitive to cold
- Sensitive to sweets
- Sensitive to biting
- Food Impaction
- Clenching or grinding
- Shifting of teeth
- Change in bite

Do you like your teeth? YES or NO

Oral Hygiene - do you use any of the following?

- Brush - _____ a day
- Dental Floss
- Fluoride Rinse
- Other : _____

My toothbrush is:

- Soft
- Medium
- Hard
- Electric
  - Sonicare
  - Oral B
  - Other

I would like additional information about:

Bleaching **Cosmetic Dentistry** **Dentures** **Implants** **Endodontics** **Other:** _____

Patient Signature : _____ **Date :** _____