



2233 W. Baseline Rd Suite #104 Tempe, AZ 8583 (602) 438-9245

Health History Form

Reason for today's visit _____

Former Dentist _____ City/State _____

Date of last dental visit _____ Date of last dental x-ray _____

How often do you floss? _____ How often do you brush? _____ Do you require a pre-medication? _____

Please check all that apply:

- Bad Breath
- Bleeding gums
- Blisters/sores/growths on lips or mouth
- Burning sensation on tongue
- Chew on one side of mouth
- Cigarette/pipe/cigar smoking
- Clicking or popping jaw
- Dry mouth
- Foreign objects
- Food collection between teeth
- Grinding teeth
- Gums swollen or tender
- Jaw pain
- Jaw tiredness
- Lip or cheek biting
- Loose teeth/broken fillings
- Fingernail biting
- Mouth pain, brushing
- Orthodontic treatment
- Pain around ear
- Periodontal treatment
- Sensitivity to cold
- Sensitivity to heat
- Sensitivity to sweets
- Sensitivity when biting
- Mouth breather
- Have you ever been diagnosed with Sleep Apnea?
- Have you ever had an overnight sleep study?
- Do you or have you used a CPAP?
- Do you wake up in the morning with headaches?
- Have you been told that you gasp for air or suddenly stop breathing while sleeping?
- Do you snore?

Health History

Physician's Name _____ Date of Last Visit _____ Other Medical Conditions not listed below _____

Have you ever taken any medications containing bisphosphonates? This includes brands such as Fosamax, Actonel, Didronel, Boniva, Aredia, and Zometa. Yes No

- AIDS/HIV
- Anemia
- Arthritis, Rheumatism
- Artificial Heart Valves
- Artificial Joints
- Asthma
- Back Problems
- Bleeding abnormally, with extractions or surgery
- Blood Disease
- Cancer
- Chemical Dependency
- Chemotherapy
- Circulatory Problems
- Congenital Heart Lesions
- Cortisone Treatments
- Cough, persistent/bloody
- Diabetes
- Dizziness
- Bone Density medication
- Cholesterol medication
- Emphysema
- Epilepsy
- Fainting
- Glaucoma
- Headaches
- Heart Murmur
- Heart Problems
- Hepatitis Type _____
- Herpes
- High Blood Pressure
- Jaundice
- Jaw Pain
- Kidney Disease
- Liver Disease
- Low Blood Pressure
- Mitral Valve Prolapse
- Nervous Problems
- Pacemaker
- Psychiatric Care
- Radiation Treatment
- Respiratory Disease
- Rheumatic Fever
- Scarlet Fever
- Seizures
- Shortness of Breath
- Sinus Trouble
- Skin Rash
- Special Diet
- Stroke
- Swollen Feet/Ankles
- Swollen Neck Glands
- Thyroid Problems
- Tonsillitis
- Tuberculosis
- Tumor or growth on head or neck
- Ulcer
- Venereal Disease
- Weight Loss/Gain

Do you wear contact lenses? Yes No Are you taking birth control pills? Yes No

Are you pregnant? Yes No Due Date: _____ Are you nursing? Yes No

Medication

List any medication you are currently taking and the correlating diagnosis: _____

Allergies

- Aspirin
- Codeine
- Dental Anesthetics
- Erythromycin
- Latex
- Metals
- Penicillin
- Sulfa
- Tetracycline
- Other _____

I authorize and give consent to perform dental services agreed between South Mountain Family Dental and its associates and patient and/or parent or guardian to be necessary or advisable including the use of anesthesia and other medication as indicated. I certify to the accuracy of the above statements regarding my medical and dental history. Payment for all treatment and services rendered are my responsibility.

Signature of patient, parent, guardian or personal representative _____ Printed name of patient, parent, guardian or personal representative _____ Date _____