

Dr. Lee Salisbury

Dr. Daniel Driscoll



Dental Health History

Last Name _____ First _____ Middle Initial _____ (Preferred) _____

Birthdate _____ SS# _____ Male _____ Female _____

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dental treatment you will receive. If you do not know the answer to a question, please leave it blank. If you need assistance in completing the form, please ask us to help.

Reason for this appointment or main concern:

Physician's Name and City: _____

Please list all MEDICATIONS you are currently taking: _____

Please list any ALLERGIES you have: _____

DENTAL/MEDICAL INFORMATION

1. When was your last dental check-up? _____ 2. When were your teeth cleaned last? _____

3. When were your last dental x-rays taken? _____ (Not sure) _____

4. Do you smoke or use smokeless tobacco? Yes No

5. Do any of your teeth have pain/sensitivity to heat, cold or pressure? Yes No

6. Do your gums bleed while brushing? Yes No

7. Have you ever had treatment for gum disease? Yes No

8. Are you happy with the whiteness of your teeth? Yes No

9. Are you happy with the overall appearance of your teeth? Yes No

10. Have you ever had any jaw pain or tenderness when chewing or opening/closing your mouth? Yes No

11. Do you have fear or significant anxiety related to dental treatment?..... Yes No

12. Have there been changes in your health within the past year? Yes No
 If yes, please explain: _____
13. Have you had treatment by a physician within the past year?..... Yes No
 If yes, please explain: _____
14. Have you ever had major surgery or been hospitalized for any reason?..... Yes No
 If yes, please explain: _____
15. Are there any medications that make you sick or ill (medicine reaction you)?..... Yes No
 If yes, please list: _____
16. (Women)Are you pregnant?..... Yes No
 If yes, what is your due date? _____

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

- | | | | | | |
|---|-----|----|---|-----|----|
| 17. AIDS/positive test HIV..... | Yes | No | 38. Hepatitis | Yes | No |
| 18. Alcohol abuse | Yes | No | 39. High or low blood pressure | Yes | No |
| 19. Anemia: low or thin blood | Yes | No | 40. Kidney or bladder disorder..... | Yes | No |
| 20. Asthma | Yes | No | 41. Latex sensitivity | Yes | No |
| 21. Blood donation rejection | Yes | No | 42. Oral ulcers or sores | Yes | No |
| 22. Blood transfusion(s) | Yes | No | 43. Prolonged bleeding (cut, injury, surgery) | Yes | No |
| 23. Blood thinner | Yes | No | 44. Radiation or x-ray treatment for cancer | Yes | No |
| 24. Bone, joint, or muscle problems | Yes | No | 45. Rheumatic fever | Yes | No |
| 25. Bronchitis/emphysema | Yes | No | 46. Seizures, convulsions or epilepsy | Yes | No |
| 26. Cancer | Yes | No | 47. Shortness of breath with normal activity | Yes | No |
| 27. Cardiac pacemaker | Yes | No | 48. Stomach or intestinal ulcers | Yes | No |
| 28. Diabetes | Yes | No | 49. Stroke | Yes | No |
| 29. Drug abuse | Yes | No | 50. Sugar diabetes | Yes | No |
| 30. Emotional problems | Yes | No | 51. TB test positive | Yes | No |
| 31. Fainting spells or blackouts | Yes | No | 52. Thyroid disorder | Yes | No |
| 32. Hearing problems | Yes | No | 53. Tuberculosis | Yes | No |
| 33. Heart Attack | Yes | No | 54. Tremors | Yes | No |
| 34. Heart Disease | Yes | No | 55. Use of tobacco products | Yes | No |
| 35. Heart Murmur..... | Yes | No | 56. Venereal disease (VD) | Yes | No |
| 36. Heart surgery/prosthetic valve | Yes | No | 57. Visual problems | Yes | No |
| 37. Hemophilia or bleeding disorder | Yes | No | 58. Other problems not listed | Yes | No |

Explain any "yes" answers to items 17-58: _____

To the best of my knowledge, I have answered the above questions truthfully. During treatment, **I will report any changes in my health**, illnesses or hospitalization, and additions/changes in medication to those listed above. I consent to the use of appropriate medications and therapy as deemed necessary. I agree to follow the instructions of the doctor or designated staff member. I fully understand that using local anesthetic/agents embodies a certain risk.

Patient Signature _____ **Date** _____

Doctor Signature _____ **Date** _____

