John M Schiefelbein, DMD, PLLC
HEALTH HISTORY

**PATIENT NAME:** _____ **BIRTHDATE:** _____

Chief dental concern: _____

| | | | |
|---|---|---|---|
| Does dental treatment make you nervous? …… | ❑Yes ❑No | **Do you have, or have you ever had any of the following?** | |
| Have you ever had any serious trouble associated with previous dentistry? …….. | ❑Yes ❑No | Pain in jaw? …… | ❑Yes ❑No |
| Are you happy with the appearance of your teeth? ……... | ❑Yes ❑No | Clicking/popping jaw? …… | ❑Yes ❑No |
| Are your teeth sensitive to cold? Heat? ……... | ❑Yes ❑No | Clenching or grinding? ……..…… | ❑Yes ❑No |
| Do you have frequent headaches? …….. | ❑Yes ❑No | Orthodontic treatment? ……... | ❑Yes ❑No |
| Do you have a dry mouth? …… | ❑Yes ❑No | Tooth sensitive to chewing or difficulty chewing? | ❑Yes ❑No |
| | | Unpleasant taste or bad breath? …… | ❑Yes ❑No |
| | | Have you ever had periodontal disease? …… | ❑Yes ❑No |

| | | |
|---|---|---|
| Are you under the care of a physician? ……... | ❑Yes ❑No | If Yes, please explain: _____ |
| Have you been hospitalized or had a major operation within the past 5 years? …… | ❑Yes ❑No | If Yes, please explain: _____ |
| Have you ever had a serious head or neck injury? …… | ❑Yes ❑No | If Yes, please explain: _____ |
| Have you been told to pre-medicate with antibiotics before dental treatment? …… | ❑Yes ❑No | If Yes, please explain: _____ |
| Have you been prescribed Aspirin, Coumadin, Plavix or any other blood thinning medications? …… | ❑Yes ❑No | If Yes, please explain: _____ |
| Have you ever taken medications containing Bisphosphonates like Fosamax®? …… | ❑Yes ❑No | If Yes, please explain: _____ |
| Do you use tobacco, smoke, vape or use marijuana? …….. | ❑Yes ❑No | |

**MEDICATIONS**: Please list all medications you are currently taking: _____
_____

**ALLERGIES**: Are you allergic to any of the following: ❑Penicillin ❑Other Antibiotics ❑ Codeine ❑Latex ❑ Metal ❑ Local Anesthetics
Other – If yes, please explain: _____

**CHECK ALL THAT APPLY:**

- ❑ Artificial Joint Date: _____
- ❑ Cancer-Malignancy Date: _____
- ❑ Joint Infection
- ❑ Hemophilia
- ❑ Diabetes
- ❑ Autoimmune disease (i.e. rheumatoid arthritis, lupus)
- ❑ Drug or Radiation-induced Immunosuppress
- ❑ AIDS/HIV Positive
- ❑ Infective Endocarditis
- ❑ Cardiac Transplant
- ❑ Congenital Heart Disease
- ❑ Artificial Heart Valve
- ❑ Heart Disease / Attack Date: _____
- ❑ Pacemaker Date Placed: _____
- ❑ Angina
- ❑ Heart Murmur/Rheumatic Fever
- ❑ Stroke Date: _____
- ❑ High / Low Blood Pressure (Circle one)
- ❑ High Cholesterol
- ❑ Breathing or Lung Problems
- ❑ Asthma
- ❑ COPD/Emphysema
- ❑ Tuberculosis or Frequent Cough
- ❑ Anemia or other Blood Disorder
- ❑ Excessive bleeding or bruising
- ❑ Hepatitis (Type _____)
- ❑ Liver Disease / Jaundice
- ❑ Kidney Disease
- ❑ Thyroid Disease
- ❑ Ulcers
- ❑ Glaucoma/Retinal surgery
- ❑ Osteoporosis
- ❑ Arthritis
- ❑ Cold Sores
- ❑ Epilepsy or Seizures
- ❑ Neurological Disorder
- ❑ Fainting/Dizziness
- ❑ Sinus Problems/Hay Fever
- ❑ Psychiatric Care
- ❑ Drug/Alcohol Addiction

**WOMEN ONLY**:
Could you be or are you planning to be pregnant? ❑ Yes ❑ No Nursing? ❑Yes ❑No Taking oral contraceptives? ❑Yes ❑No

**COMMENTS:** _____
_____

**To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.**

**SIGNATURE OF PATIENT, PARENT or GUARDIAN**: _____ **Date**: _____

(Office Use Only) Initials: _____ Date: _____