

HEALTH HISTORY INFORMATION



Ryan Rush
DDS PLLC

Patient's Name _____ Date _____
Last First Middle Initial

DENTAL HISTORY

What is the date of your last dental exam and what services were performed? _____/unknown
 What is the date of your most recent dental x-rays? _____/unknown

YES/NO

- Do you have a specific tooth or issue you would like addressed today?
If yes, please describe _____
 - Have you ever been told you have periodontal (gum) disease?
 - Are your teeth sensitive to cold, hot, sweets, or pressure? If yes, please circle all that apply
 - Do you ever have clicking, popping or discomfort in your jaw?
 - Do you have a history of TMD/TMJ?
 - Do you grind or clench your teeth? If yes, does it cause headaches? YES/NO
 - Do you smoke or chew tobacco?
 - Do you have any sores or growths in your mouth?
 - Do you get nervous about seeing the dentist or hygienist?
 - Have you had any complications with previous dental treatment or local anesthesia? If yes, please describe _____
- Rate how you feel about your smile 1 to 10 _____

MEDICAL HISTORY

YES/NO

- Are you required to take Premedications by your physician?** If yes, please indicate _____
- Do you have an allergy to Penicillin?
- Do you have *any allergies*? If yes, please describe _____
- Are you under the care of a medical physician for any medical treatments? If yes, for what condition? _____
- When was your last physical exam? _____
- Do you have any personal history of cancer? If so, please indicate the treatment you received (chemo, radiation, etc.) _____
- Do you have any personal history of addiction or alcoholism?

Do you have now, or have you ever had any of the following? Please check the appropriate boxes.

YES/NO	YES/NO	YES/NO	YES/NO
<input type="checkbox"/> <input type="checkbox"/> Acid reflux/GERD	<input type="checkbox"/> <input type="checkbox"/> Epilepsy or seizures	<input type="checkbox"/> <input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> <input type="checkbox"/> Sinus trouble
<input type="checkbox"/> <input type="checkbox"/> AIDS	<input type="checkbox"/> <input type="checkbox"/> Fainting or dizziness	<input type="checkbox"/> <input type="checkbox"/> Leukemia	<input type="checkbox"/> <input type="checkbox"/> Stroke
<input type="checkbox"/> <input type="checkbox"/> Artificial heart valve	<input type="checkbox"/> <input type="checkbox"/> Heart murmur	<input type="checkbox"/> <input type="checkbox"/> Low blood pressure	<input type="checkbox"/> <input type="checkbox"/> Stomach ulcers
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Heart surgery	<input type="checkbox"/> <input type="checkbox"/> Mitral valve prolapse	<input type="checkbox"/> <input type="checkbox"/> Thyroid problems
<input type="checkbox"/> <input type="checkbox"/> Autism	<input type="checkbox"/> <input type="checkbox"/> Heart trouble/disease	<input type="checkbox"/> <input type="checkbox"/> Multiple myeloma	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Bleeding problems	<input type="checkbox"/> <input type="checkbox"/> Hepatitis A/B/C <small>please circle</small>	<input type="checkbox"/> <input type="checkbox"/> Nervousness	<input type="checkbox"/> <input type="checkbox"/> Tumors or growths
<input type="checkbox"/> <input type="checkbox"/> Cold sores	<input type="checkbox"/> <input type="checkbox"/> Herpes	<input type="checkbox"/> <input type="checkbox"/> Osteoporosis	Other _____
<input type="checkbox"/> <input type="checkbox"/> Developmental delays	<input type="checkbox"/> <input type="checkbox"/> High blood pressure	<input type="checkbox"/> <input type="checkbox"/> Pacemaker	_____
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> HIV positive	<input type="checkbox"/> <input type="checkbox"/> Psychiatric care	_____
<input type="checkbox"/> <input type="checkbox"/> Emphysema	<input type="checkbox"/> <input type="checkbox"/> HPV – human papilloma virus	<input type="checkbox"/> <input type="checkbox"/> Rheumatic fever	

YES/NO

- If you indicated above that you have high blood pressure, are you currently taking medication for this?
- Do you have any artificial joints? If yes, please indicate where and when _____
- Have you ever taken bisphosphate drugs such as, Zometa, Aredia, Actonel or Fosamax?
- Do you take Aspirin, Nitroglycerin, or any other drugs for heart problems?

Please list any medications or supplements you are currently taking: (please use the back of this page if necessary)

Women only – Are you currently pregnant or nursing? YES/NO
 Are you currently taking contraceptives or other hormones? YES/NO

 Patient/Guardian Signature