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 by your physician to take antibiotics before dental appointments?** _____ If yes, please indicate why
☐ ☐ 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
☐ ☐ Acid reflux/GERD	☐ ☐ Epilepsy or seizures	☐ ☐ Hypoglycemia	☐ ☐ Sinus trouble
☐ ☐ AIDS	☐ ☐ Fainting or dizziness	☐ ☐ Leukemia	☐ ☐ Stroke
☐ ☐ Artificial heart valve	☐ ☐ Heart murmur	☐ ☐ Low blood pressure	☐ ☐ Stomach ulcers
☐ ☐ Asthma	☐ ☐ Heart surgery	☐ ☐ Mitral valve prolapse	☐ ☐ Thyroid problems
☐ ☐ Autism	☐ ☐ Heart trouble/disease	☐ ☐ Multiple myeloma	☐ ☐ Tuberculosis
☐ ☐ Bleeding problems	☐ ☐ Hepatitis A/B/C please circle	☐ ☐ Nervousness	☐ ☐ Tumors or growths
☐ ☐ Cold sores	☐ ☐ Herpes	☐ ☐ Osteoporosis	Other _____
☐ ☐ Developmental delays	☐ ☐ High blood pressure	☐ ☐ Pacemaker	_____
☐ ☐ Diabetes	☐ ☐ HIV positive	☐ ☐ Psychiatric care	_____
☐ ☐ Emphysema	☐ ☐ HPV – human papilloma virus	☐ ☐ 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)

_____
_____
_____

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

_____
Patient/Guardian Signature