J. Chris Bock, D.M.D.
Paul G. Hutchinson, DMD

HEALTH HISTORY

Patient Name: ______________________ Date of Birth: ______________

Medical Doctor's Name: ______________________ Physician's Ph# ______________

Date of last physical? ______________________

- ❑ AIDS/HIV
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Bleeding abnormally
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Heart Lesions
- ❑ Cortisone Treatments
- ❑ Cough, persistent or bloody
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fainting or dizziness
- ❑ Fen/Phen use
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart Problems
- ❑ Hepatitis ____
- ❑ Herpes
- ❑ High/Low Blood Pressure
- ❑ Jaundice
- ❑ Jaw Pain
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mitral Valve Prolapse
- ❑ Nervous Problems
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Shortness of Breath
- ❑ Sinus Trouble
- ❑ Sinus Trouble
- ❑ Skin Rash
- ❑ Stoke
- ❑ Swelling of Feet or Ankles
- ❑ Swollen Neck Glands
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumor or growth on head or neck
- ❑ Ulcer
- ❑ Venereal Disease
- ❑ Weight loss or gain, unexplained
- ❑ Other ______________ ______________ ______________

Women: Are you now or do you plan to become pregnant? **Yes/No** Due Date: ______________

Are you nursing? **Yes/No** Taking birth control pills? **Yes/No**

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis

____
____
____
____

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Latex
- ☐ Iodine
- ☐ Penicillin
- ☐ Sulfa

Metals, if so, type: ______________

Other ______________________

DENTAL HISTORY

Reason for today's visit ______________________________

Former Dentist ______________________ City/State ______________

Last Dental Visit: ______________________ Last Dental X-rays ______________

- ☐Cigarette, pipe or cigar smoking
- ☐Clicking or popping jaw
- ☐ Jaw pain or tenderness
- ☐ Food Collection between teeth
- ☐ Dry Mouth
- ☐ Grinding Teeth
- ☐ Gums, swollen or tender
- ☐ Lip or cheek biting
- ☐ Loose teeth or broken fillings
- ☐ Mouth breathing
- ☐ Mouth pain
- ☐ Pain around ear
- ☐ Chronic or recurrent sinus problems
- ☐ Periodontal treatment
- ☐ Orthodontic treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in mouth
- ☐ Rigorous sports including, but not limited to football, baseball, wresting
- ☐ How often do you floss? ______
- ☐ How often do you brush? ______

Other dental concerns: ______________________________

Signature ______________________ Date ______________

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