Easton Bright Smiles
Cosmetic & Family Dentistry

# HEALTH HISTORY

First Name_____Last Name_____ DOB_____

## DENTAL HISTORY

Do your gums bleed when you brush or floss? ( )Yes / ( )No
Your teeth sensitive to cold, hot, sweets or pressure? ( )Yes / ( )No
Does food or floss catch between your teeth? ( )Yes / ( )No
Is your mouth dry? ( )Yes / ( )No
Do you have an unpleasant taste or odor? ( )Yes / ( )No
Do you smoke or use tobacco products? ( )Yes / ( )No
How many times a day do you brush your teeth?_____Floss_____
Are you currently experiencing dental pain/discomfort? ( )Yes / ( )No
Any problems associated with previous dental treatment? ( )Yes / ( )No

Has the fear of discomfort kept you from
Regular dental visits? ( )Yes / ( )No

When was your last dental appointment? _____
How long has it been since last complete examination
with a full series of x-rays?_____
How do you feel about your smile?_____

What propted you to seek dental care at this time?

Please rank the following in the order in which they would
KEEP YOU FROM having dental treatment.
___ Fear of pain, ____Cost of Treatment, ____Missing Work

Do you have earaches or neck pains ( )Yes / ( )No

Do you have any clicking, popping or
discomfort in the jaw? ( )Yes / ( )No
Do you grind your teeth? ( )Yes / ( )No
Do you have any sores or ulcers in your mouth? ( )Yes / ( )No
Do you wear dentures or partials? ( )Yes ( )No

Have you ever had a serious injury to
your head or mouth? ( )Yes / ( )No

## MEDICAL INFORMATION

*Please mark "Yes" or "No" to indicate if you have any of the following*

Aids ( )Yes / ( )No
Anemia ( )Yes / ( )No
Arthritis, Rheumatism ( )Yes / ( )No
Artificial Heart Values ( )Yes / ( )No
Artificial Joints ( )Yes / ( )No
Asthma ( )Yes / ( )No
Back Problems ( )Yes / ( )No
Bleeding Abnormally,
with extractions / surgery ( )Yes / ( )No
Blood Disease ( )Yes / ( )No
Cancer ( )Yes / ( )No
Chemical Dependency ( )Yes / ( )No
Chemotherapy ( )Yes / ( )No
Circulatory Problems ( )Yes / ( )No
Congenital Heart Lesions ( )Yes / ( )No
Cortisone Treatments ( )Yes / ( )No
Cough, Persistant / Bloody ( )Yes / ( )No
Diabetes ( )Yes / ( )No
Emphysema ( )Yes / ( )No
Do you wear contact
lenses ( )Yes / ( )No
Epilepsy ( )Yes / ( )No

Faiting or Dizziness ( )Yes / ( )No
Glaucoma ( )Yes / ( )No
Headaches ( )Yes / ( )No
Heart Murmur ( )Yes / ( )No
Heart Problems ( )Yes / ( )No
Hepatitis ( )Yes / ( )No
Type _____
Herpes ( )Yes / ( )No
High Blood Pressure ( )Yes / ( )No
HIV Positive ( )Yes / ( )No
Jaundice ( )Yes / ( )No
Jaw Pain ( )Yes / ( )No
Kidney Disease ( )Yes / ( )No
Liver Disease ( )Yes / ( )No
Low Blood Pressure ( )Yes / ( )No
Mitral Valve Problems ( )Yes / ( )No
Nervous Problems ( )Yes / ( )No
Pacemaker ( )Yes / ( )No
Ulcer ( )Yes / ( )No
Veneral Disease ( )Yes / ( )No
Weight Loss
Unexplained ( )Yes / ( )No

Psychiatric Care ( )Yes / ( )No
Radiation Treatment ( )Yes / ( )No
Respiratory Disease ( )Yes / ( )No
Rheumatic Fever ( )Yes / ( )No
Scarlet Fever ( )Yes / ( )No
Shortness of Breath ( )Yes / ( )No
Sinus Trouble ( )Yes / ( )No
Skin Rash ( )Yes / ( )No
Special Diet ( )Yes / ( )No
Stroke ( )Yes / ( )No
Swelling of Feet/Ankles ( )Yes / ( )No
Swollen Neck Glands ( )Yes / ( )No
Thyroid Problems ( )Yes / ( )No
Tonsillitis ( )Yes / ( )No
Tuberculosis ( )Yes / ( )No
Tumor or growth on
head or neck ( )Yes / ( )No

**WOMEN**

Are you pregnant ( )Yes / ( )No
Due Date _____
Taking Birth control pills ( )Yes / ( )No
Are you lactating ( )Yes / ( )No

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| **Medications** | **Allergies** | |
|---|---|---|
| List Medications you are currently taking | Aspirin | ( )Yes / ( )No |
| _____ | Barbiturates (sleeping pills) | ( )Yes / ( )No |
| _____ | Codeine | ( )Yes / ( )No |
| _____ | Iodine | ( )Yes / ( )No |
| | Latex | ( )Yes / ( )No |
| Pharmacy Name | Penicillin | ( )Yes / ( )No |
| _____ | Sulfa | ( )Yes / ( )No |
| Phone _____ | Local Anasthetic (Novacaine) | ( )Yes / ( )No |
| | Other _____ | |

## OTHER INFORMATION

| | |
|---|---|
| **Have you ever been told that you need "antibiotic prophylaxis" prior to dental treatment?** | ( )Yes / ( )No |
| Have you had any adverse reactions to any drugs? | ( )Yes / ( )No |
| Adverse reactions to any medical or dental treatment? | ( )Yes / ( )No |
| Are you currently under the care of an M.D.? | ( )Yes / ( )No |
| For What? _____ | |
| Is there anything else we should know about your medical history? | ( )Yes / ( )No |
| Describe - _____ | |
| If we could offer you a simple, effective way of whitening your teeth, would you be interested? | ( )Yes / ( )No |

____ All of the above information is correct to the best of my knowledge

____ We reserve the right to charge for appointments cancelled or broken without 24 hours of advance notice. Charge will be $25.00 per 1/2 hr of scheduled procedure time

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold Easton Bright Smiles, my dentist, and his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient / Legal Guardian_____Date_____