Monte Morgan DMD

Health History

FORM 102 / R220222

PATIENT NAME _____ BIRTH DATE ____/____/_____ DATE CREATED ____/____/_____

WE WANT YOU TO HAVE AN EXCELLENT EXPERIENCE IN OUR OFFICE. PLEASE LET US KNOW HOW WE CAN HELP YOU.

PLEASE ANSWER THE FOLLOWING:

What is the reason for your visit with our office? _____

When was your last dental visit? _____

How often do you brush your teeth? _____

Do you use a manual or electric toothbrush? _____

(Y) (N) Are you happy with the appearance of your teeth? _____

(Y) (N) Have you ever had an upsetting experience in the dental office? _____

(Y) (N) Is there anything about dental treatment that bothers you? _____

(Y) (N) Do you see a physician regularly? Physicians Name: _____ Phone Number: _____

(Y) (N) Do your gums bleed while brushing?
(Y) (N) Do your gums bleed while flossing?
(Y) (N) Do you feel pain in any of your teeth?
(Y) (N) Are your teeth sensitive?
(Y) (N) Have you noticed any teeth loosening?
(Y) (N) Does food get caught in your teeth?
(Y) (N) Do you have mouth sores or lumps?
(Y) (N) Do you have any jaw issues?
(Y) (N) Do you have frequent headaches?
(Y) (N) Do you clench or grind your teeth?
(Y) (N) Have you had orthodontics?

HEALTH PROBLEMS OR MEDICATION(S) YOU MAY BE TAKING COULD HAVE AN IMPORTANT CONNECTION WITH THE DENTISTRY YOU ARE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS:

(Y) (N) Are you in good health?
(Y) (N) Do you have a persistent cough?
(Y) (N) Have you had any abnormal bleeding?
(Y) (N) Do you bruise easily?
(Y) (N) Do you have a condition not listed?
(Y) (N) Do you use alcohol?
(Y) (N) Do you use tobacco?
(Y) (N) Do you use other controlled substances?
(Y) (N) Do you take medication for osteoporosis?

WOMEN ONLY:

(Y) (N) Are you pregnant? (Y) (N) Are you nursing? (Y) (N) Are you taking birth control pills? (Y) (N) Are you possibly pregnant?

ARE YOU ALLERGIC, OR HAVE HAD A REACTION, TO ANY OF THE FOLLOWING? *(MARK ALL THAT APPLY)*

◯ Local Anesthetics ◯ Penicillin/Sulfa or other antibiotics ◯ Aspirin ◯ Iodine ◯ Latex ◯ Other (please list) _____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

(Y) (N) AIDS or HIV Infection
(Y) (N) Allergies
(Y) (N) Anemia
(Y) (N) Arthritis or Rheumatism
(Y) (N) Asthma
(Y) (N) Cancer
(Y) (N) Cancer treatment
(Y) (N) Cough that produces blood
(Y) (N) Diabetes I or II
(Y) (N) Epilepsy or Seizures
(Y) (N) Fainting Spells or Hypoglycemia
(Y) (N) Glaucoma
(Y) (N) Hay Fever
(Y) (N) Heart Defect or Murmur
(Y) (N) Heart Surgery
(Y) (N) Heart Trouble, Heart Attack, or Angina
(Y) (N) Hepatitis A, B, or C
(Y) (N) High Blood Pressure
(Y) (N) Hives or Skin Rash
(Y) (N) Immunosuppressed Condition
(Y) (N) Joint Replacement or Implant
(Y) (N) Kidney Trouble
(Y) (N) Leukemia
(Y) (N) Low Blood Pressure
(Y) (N) Lung or Breathing Problems
(Y) (N) Memory Problems
(Y) (N) Pacemaker
(Y) (N) Psychiatric Care
(Y) (N) Sexually Transmitted Disease
(Y) (N) Sinus Problems
(Y) (N) Stroke
(Y) (N) Thyroid Problems
(Y) (N) Tuberculosis

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

_____

_____

PATIENT SIGNATURE (PARENT / LEGAL GUARDIAN IF MINOR) _____ DATE ____/____/_____

OFFICE USE ONLY

DATE	COMMENTS	INITIALS