Health History Update

Name_____

Dental

Are you currently experiencing any dental problems? Y / N
Do you have any sensitivity when brushing, drinking or eating? Y / N
Do you brush or floss on a routine basis? Y / N
Do you notice any bleeding when you brush or floss? Y / N
Are you happy with your smile? Y / N
Do you have any clicking, popping or discomfort in the jaw joint? Y / N
Do you grind? Y / N

Medical

Any changes in your health since your last visit? Y / N If yes,
explain_____
Have you seen your physician since your last visit? Y / N
Any surgeries or medical procedures in the last 6 months? Y / N If yes,
explain_____
Have you had a knee/hip or other joint replacement? Y / N
Do you have a pacemaker? Y / N
Are you pregnant? Y / N
Provide a list of all Prescription/Over the counter medications and herbal supplements:

Are you allergic to any medications? Y/ N If yes, explain_____

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications, can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

Patient/Parent or Guardian Signature_____ **Date**_____