HEALTH HISTORY FORM for Mountain West Family Dentistry

PATIENT NAME _____ **BIRTH DATE** _____/_____/_____

DENTAL INFORMATION

Approximate date of last dental check-up _____

How many sodas, sports drinks, or juices do you consume in a day on average? _____

Please check if you have any of these concerns:

- Nervous about dental treatment
- Tooth pain (scale of 1-10 _____)
- Sensitivity
- Jaw pain
- Mouth sores
- History of periodontal treatment/deep cleaning
- Clench/Grind teeth
- Appearance of teeth
- Bite issues
- Bad breath

ALLERGIES:
- Penicillin
- Aspirin
- Codeine
- Latex
- Sulfa
- Other:

_____
_____
_____

Please list current medications and doses (including over-the-counter and any birth control)

_____ _____

_____ _____

_____ _____

Please list an emergency contact and phone number_____

MEDICAL HISTORY

Women: Pregnant or anticipate becoming pregnant Y / N

Height_____ Weight_____

Physician: Name_____ Phone #_____ Pharmacy_____

Please check if you have any of the following:

Cancer
- Cancer surgery
- Chemotherapy
- Radiation

Cardiovascular
- High blood pressure
- High cholesterol
- Heart attack
- Stroke/TIA
- Heart surgery
- Valve replacement
- Heart failure
- Heart murmur
- Other: _____

Drug Use
- Tobacco
- Alcohol abuse
- Chemical dependency (narcotics)
- Recreational drugs

Endocrine/Hepatic
- Diabetes: (circle type: I II)
- Thyroid disease/problem
- Liver disease/problem
- Jaundice
- Hepatitis: (circle: A B C)

Eyes/Ears
- Glaucoma
- Impaired vision
- Impaired hearing

Gastrointestinal
- Acid Reflux/GERD
- Irritable bowel syndrome
- Stomach ulcers

Hematologic
- Anemia
- Sickle cell disease
- Abnormal/excessive bleeding

Immunologic/Rheumatologic
- Arthritis
- Lupus
- Sjogren's Syndrome

Infections
- HIV/AIDS
- STD's/HPV
- Cold sores/Oral Herpes
- Tuberculosis
- Chicken Pox/Shingles

Mental Health
- Bipolar disorder
- Depression
- Anxiety
- Eating disorder
- Sleep disorder/Insomnia
- PTSD/Trauma

Musculoskeletal
- Artificial joint
- Fibromyalgia
- Osteoporosis/Osteopenia
- Bisphosphonate use

Neurologic
- Epilepsy/seizures
- Migraines
- Parkinson's disease
- Multiple Sclerosis
- Alzheimer's/Dementia
- Autism Spectrum Disorder
- ADD/ADHD

Renal
- Dialysis
- Kidney disorder

Respiratory
- Asthma
- Emphysema/COPD
- Sleep apnea
- Difficulty breathing

Skin
- Hives
- Other skin lesions/tumors

Please list any other medical concerns not listed and history of surgeries:

_____
_____
_____
_____
_____

I authorize that all the information on this form is true and correct.

I give my permission for the doctor to do all diagnostics and x-rays as required for my treat

Signature of Patient/Guardian _____ **Date** _____/_____/_____