Health History
DIXON ORTHODONTIC DENTAL GROUP

Patient Name: _____Birth Date: _____ Date: _____

Primary reason for this dental appointment: (Circle) Examination Emergency Consultation

Circle Appropriate Answer (leave blank if you do not understand question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why? _____
4. Yes No Are you being treated by a physician now? Why ?_____
   Date of last medical exam:_____ Date of last Dental Exam:_____
5. Yes No Are you taking any medications or substances? Please list: _____
6. Yes No Are you allergic to any medications, pills, or drugs?

Please circle: Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Other_____

Dental History

7. Yes No Are you in pain now?
8. Yes No Do you have a specific dental problem? Describe _____
9. Yes No Do you have dental examinations on a routine basis? Last visit? _____
10. Yes No Do you think you have active decay or gum disease?
11. Yes No Do you brush and floss on a routine basis?
12. Yes No Do your gums ever bleed? Describe_____
13. Yes No Do you like your smile?
14. Yes No Does food catch between your teeth? Any loose teeth?
15. Yes No Do you ever have clicking, popping, or discomfort in the jaw joint? Do you brux or grind?
    Approximate date of last full mouth x-rays (16 or more films) _____ Bitewing (4 films) _____

Medical History

Do you have or have you had any of the following? Please check appropriate boxes. If yes to * questions, call prior to your appointment.

	Yes	No			Yes	No			Yes	No			Yes	No	
16.	☐	☐	Heart trouble / Disease	35.	☐	☐	Bloody stools	54.	☐	☐	Tuberculosis	73.	☐	☐	Kidney problems
17.	☐	☐	Irregular heart beat	36.	☐	☐	Bruise easily	55.	☐	☐	Cancer	74.	☐	☐	Renal dialysis
18.	☐	☐	Angina / Chest pain	37.	☐	☐	Anemia	56.	☐	☐	Radiation therapy	75.	☐	☐	Thyroid Disease
19.	☐	☐	Heart attack / Failure	38.	☐	☐	Excessive bleeding	57.	☐	☐	Chemotherapy	76.	☐	☐	Arthritis / Gout
20.	☐	☐	Congenital heart disorder	39.	☐	☐	Sickle cell disease	58.	☐	☐	Stomach disease	77.	☐	☐	Rheumatism
21.	☐	☐	***Heart murmur** *	40.	☐	☐	Hemophilia	59.	☐	☐	Ulcers	78.	☐	☐	Pain in jaw joint
22.	☐	☐	***Mitral valve prolapse** *	41.	☐	☐	Leukemia	60.	☐	☐	Recent weight loss	79.	☐	☐	Venereal disease
23.	☐	☐	***Rheumatic fever** *	42.	☐	☐	Blood transfusion	61.	☐	☐	Frequent diarrhea	80.	☐	☐	AIDS / HIV+
24.	☐	☐	***Artificial heart valve** *	43.	☐	☐	Swelling of limbs	62.	☐	☐	Diabetes	81.	☐	☐	Genital herpes
25.	☐	☐	***Heart pace maker** *	44.	☐	☐	Lung disease	63.	☐	☐	Excessive thirst	82.	☐	☐	Glaucoma
26.	☐	☐	***Artificial joint** *	45.	☐	☐	Breathing problems	64.	☐	☐	Hypoglycemia	83.	☐	☐	Contact lenses
27.	☐	☐	Heart surgery	46.	☐	☐	Shortness of breath	65.	☐	☐	Liver disease	84.	☐	☐	Cold sores
28.	☐	☐	High blood pressure	47.	☐	☐	Frequent cough	66.	☐	☐	Hepatitis A	85.	☐	☐	Fever blisters
29.	☐	☐	Low blood pressure	48.	☐	☐	Hay fever	67.	☐	☐	Hepatitis B or C	86.	☐	☐	Herpes
30.	☐	☐	Blood disease	49.	☐	☐	Sinus trouble	68.	☐	☐	Night sweats	87.	☐	☐	Convulsions
31.	☐	☐	Stroke	50.	☐	☐	Asthma	69.	☐	☐	Dry mouth	88.	☐	☐	Epilepsy or seizure
32.	☐	☐	Scarlet Fever	51.	☐	☐	Emphysema	70.	☐	☐	Yellow jaundice	89.	☐	☐	Fainting or dizziness
33.	☐	☐	Unexplained fever	52.	☐	☐	Allergies (Medicines)	71.	☐	☐	Psychiatric care	90.	☐	☐	Alzheimer's disease
34.	☐	☐	Hives or rash	53.	☐	☐	Allergies (Pollen / Dust)	72.	☐	☐	Drug addiction	91.	☐	☐	Tumors or growths

Yes No Have you ever had any other serious illness not checked above? Discuss _____

Yes No Do you wish to talk to the dentist privately about any problem?

Yes No Have your past experiences in a dental office always been positive?

Women (please circle) Pregnant / trying to get pregnant Nursing Taking oral contraceptives

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____

Patient Signature (parent or guardian)

Reviewed by Doctor _____ Date_____ BP _____

History review and significant findings _____

Medical Updates

Date	Exceptions		Patient's signature	Reviewed by
_____	_____	None ☐	_____	_____
_____	_____	None ☐	_____	_____
_____	_____	None ☐	_____	_____
_____	_____	None ☐	_____	_____
		None ☐		