Patient Health History

Sumner Smiles Dentistry

Patient Name:____ Date:________________________________

How often do you brush?_____________ How often do you floss? _____________ Manual or Electric tooth brush?
Physicians Name:____________________________________ Date of last visit:_______________________
Physicians Phone # and address:____

Please check all that apply:

- ☐ Bad Breath/Unpleasant Taste
- ☐ Burning Tongue/Lips
- ☐ Sensitivity to Heat
- ☐ Bleeding Gums
- ☐ Loose Teeth or Broken Fillings
- ☐ Sensitivity to Sweets
- ☐ Finger Nail Biting
- ☐ Pain Around Ear
- ☐ Frequent Headaches
- ☐ Clenching/Grinding teeth
- ☐ Periodontal Treatment
- ☐ Shifting Teeth
- ☐ Lip or Cheek Biting
- ☐ Sensitivity to Cold
- ☐ Food Impaction

Do you have or have you had: (please mark all that apply)

- ☐ Anemia
- ☐ Chemotherapy
- ☐ Radiation
- ☐ Pacemaker
- ☐ Arthritis, Rheumatism
- ☐ Diabetes
- ☐ Jaw Pain
- ☐ Respiratory Disease
- ☐ Artificial Heart Valves
- ☐ Glaucoma
- ☐ Latex Allergy
- ☐ Sinus Trouble
- ☐ Artificial Joints
- ☐ Heart Problems
- ☐ Kidney Disease
- ☐ Thyroid Problems
- ☐ Asthma
- ☐ Hepatitis type_____
- ☐ Liver Disease
- ☐ Tuberculosis
- ☐ Back Problems
- ☐ Herpes
- ☐ Low Blood Pressure
- ☐ Stroke
- ☐ Bleeding Abnormally
- ☐ Cancer / Tumor
- ☐ High Cholesterol
- ☐ Ulcer
- ☐ High Blood Pressure
- ☐ HIV Positive/AIDS
- ☐ Other_____________
- ☐ Other ___________

	Yes	No		Yes	No
Have you ever had an Allergic reaction to:			Do you use tobacco?		
Local Anesthetics (ie: novocaine)			Do you use alcohol? (social) (other)		
Penicillin or other Antibiotics			Do you or have you used cocaine, Methamphetamine or other drugs?		
Sulfa Drugs					
Aspirin/Tylenol			Do you have abnormal bleeding with injury?		
(Other)_________________________________			**For Women;** are you taking Birth Control		
History of bisphosphonate, (current or past)			Pregnant or Nursing		

Have you had any serious illnesses or operations Yes No (If yes, please describe)

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List all Medications you are currently taking and the correlating diagnosis:

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Patient/Guardian Signature ____ Date _______________________