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

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

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

	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)

_____

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

_____

_____

_____
_____

Patient/Guardian Signature _____ Date _____