Health History

Name_____ Birth Date_____ Today's Date_____

1. Are you in good health?	YES	NO
2. Have there been any changes in your health within the past year?	YES	NO
3. Are you under the care of a physician?	YES	NO
4. Have you ever been hospitalized for any surgical operation or serious illness?	YES	NO
Please explain:_____		
5. Are you taking any medications including OTC medicine and premedication?	YES	NO
Please list:_____		
_____		
6. Have you had any abnormal bleeding?	YES	NO
7. Do you use tobacco?	YES	NO
How often and how many?_____		
8. Do you use alcohol?	YES	NO
9. Do you use controlled substances (cocaine, methamphetamine, opioids)?	YES	NO
10: Are you allergic to any of the following?		
Local anesthetics	YES	NO
Penicillin or other antibiotics	YES	NO
Sulfa drugs	YES	NO
Codeine	YES	NO
Aspirin	YES	NO
Latex	YES	NO
Seasonal	YES	NO
Other_____		
11. Do you have or have you ever had any of the following?		
Scarlet fever, rheumatic fever, or rheumatic heart disease	YES	NO
Heart defect, heart murmur, or artificial valves	YES	NO
Heart trouble, heart attack, or angina	YES	NO
Pacemaker	YES	NO
High blood pressure	YES	NO
Low blood pressure	YES	NO
Hepatitis A, B, C, D, or E (please circle type)	YES	NO
Stroke	YES	NO
Sinus trouble	YES	NO
Emphysema, COPD, or persistent cough	YES	NO
Asthma or hay fever	YES	NO
Hives or skin rash	YES	NO
Seizures (epilepsy) or fainting spells	YES	NO
Diabetes	YES	NO
HIV/AIDS	YES	NO
Herpes	YES	NO
HPV	YES	NO
Thyroid disease	YES	NO
Arthritis	YES	NO
Joint replacement or implant	YES	NO
Stomach problems or GERD	YES	NO
Kidney disease	YES	NO
Tuberculosis or cough producing blood	YES	NO
Cancer	YES	NO
Sexually Transmitted Infection	YES	NO
Anemia	YES	NO
12. Any other condition not listed_____		
Women Only		
13. Are you pregnant or think you may be pregnant?	YES	NO
14. Are you nursing?	YES	NO
15. Are you taking birth control pills?	YES	NO

The above questions have been answered accurately and to the best of my knowledge. I understand that providing false or incorrect information can be detrimental to my health. I will report any changes to my medical history to my clinician prior to treatment.

_____ _____

Signature Date

Dental History

Name_____ Date_____

What brings you to our office today?

_____

_____

How did you hear about our office?

_____

_____

Have you had any problems with past dental treatment that we should know about?

_____

_____

When was your last cleaning and exam? (approx.)

_____

Do you have any pain or sensitivity in your mouth right now? If so, where?

_____

Are there any aspects of your smile that you do not like and/or want to change?

_____

_____

On a scale of 1-10, how would you rate: (1-low 10-high)

1. Your overall dental health _____
2. The stability and comfort of your bite _____
3. The esthetics of your smile _____
4. Your previous dentist and the level of care received _____

Have you ever had any problems with your temporomandibular joint (TMJ)? Please explain.

_____

_____

Does your TMJ ever become tender or hurt when you chew, talk, or open wide? YES NO

Do you ever hear any clicks, pops, or grinding sounds in your TMJ? YES NO

Were there ever any such sounds in the past that have since gone away? YES NO

Does your jaw ever get stuck/locked open or closed? YES NO

Do you have difficulty opening your jaw? YES NO

Initials: _____

New England Dental Associates
233 West Central Street
Franklin, MA 02038
508-541-6886