HEALTH HISTORY

Metrowest Prosthodontics

Name:_________________________ Date:_______________ Cell Phone #:_______________

Do you have or have you had any of the following? Please check “YES” or “NO”

Heart Problems:

- High or Low Blood Pressure…………….. ☐ Yes | ☐ No
- **Bouts of infective endocarditis……….. ☐ Yes | ☐ No
- **Artificial Valve, Pacemaker or Stent… ☐ Yes | ☐ No
- Arteriosclerosis…………….…………….☐ Yes | ☐ No
- Heart Attack or Angina Pectoris…..….☐ Yes | ☐ No
- Heart Medications or Nitroglycerin…..☐ Yes | ☐ No
- **Cardiac transplant/developed valvulitis ☐ Yes | ☐ No
- **Rare/exotic congenital heart disease excluding MVP (Mitral Valve Prolapse)…………………… ☐ Yes | ☐ No

Blood Problems:

- Easy Bruising……………………..……..☐ Yes | ☐ No
- Abnormal Bleeding……………...…….☐ Yes | ☐ No
- Blood Thinners(Coumadin, Plavix or Aspirin) ☐ Yes | ☐ No
- Circulatory Problems………...……... ☐ Yes | ☐ No
- Hemophilia……………..……………..☐ Yes | ☐ No
- Low Blood Sugar or Anemia…….….. ☐ Yes | ☐ No

Respiratory Problems:

- Asthma, Emphysema……...…………☐ Yes | ☐ No
- Tuberculosis…………………….…….. ☐ Yes | ☐ No
- Chronic Bronchitis………….……….…☐ Yes | ☐ No

- Sinus Troubles………………………………☐ Yes | ☐ No
- Frequent or Severe Headaches…………☐ Yes | ☐ No
- Fainting Spells, Seizures or Epilepsy……… ☐ Yes | ☐ No

- Thyroid …………………………………….☐ Yes | ☐ No

Any Health Concerns we should know about?

Bone or Joint Problems:

- Joint Replacement(Hip,Pins,Plates,etc)… ☐ Yes | ☐ No
- Implants……………..……………………☐ Yes | ☐ No
- Arthritis or Osteoporosis……….……. ☐ Yes | ☐ No
- ++Taking Bisphosphonates(Fosamax, Boniva) ☐ Yes | ☐ No
- Taking Corticosteroids…………………..☐ Yes | ☐ No
- Cancer(Chemotherapy or Radiation)…. ☐ Yes | ☐ No
- Tumors or Benign Growths………………☐ Yes | ☐ No

Allergic Reactions:

- Aspirin, Acetaminophen, or Ibuprofen…..☐ Yes | ☐ No
- Codeine or Other Narcotics……………..☐ Yes | ☐ No
- Dental Anesthetics……………...……....☐ Yes | ☐ No
- Sensitivity to Epinephrine(Vasoconstrictor)….☐ Yes | ☐ No
- Antibiotics (Penicillin or Other)……..…..☐ Yes | ☐ No
- Sedatives (Valium) or Sleeping Pills…..…☐ Yes | ☐ No
- Latex (Allergy or Sensitivity)……….……..☐ Yes | ☐ No
- Other: ______________________

- Diabetes…………………………………………☐ Yes | ☐ No
- Any Physical Limitations………………………☐ Yes | ☐ No
- Hearing Limitations…………………………...☐ Yes | ☐ No
- Glaucoma or Contact Lenses………………☐ Yes | ☐ No
- Psychiatric Treatment…………………..…...☐ Yes | ☐ No
- Depression or Anxiety Disorder………………☐ Yes | ☐ No
- HIV or Aids…………………………………………☐ Yes | ☐ No
- Hepatitis A, B or C…………………………… ☐ Yes | ☐ No
- Liver or Kidney Issues……………………….…☐ Yes | ☐ No
- Drug or Alcohol Abuse Issues…………………☐ Yes | ☐ No
- Smoke or Chew Tobacco………………...….☐ Yes | ☐ No

Woman

- Are you pregnant?............................☐ Yes | ☐ No
- Taking Hormones or Contraception? ☐ Yes | ☐ No

Name or Patient,
Parent or Guardian:______________________________ **Signature**: ______________________

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Name:____ Date:______________________

Do you require "Premedication" with an antibiotic prior to dental treatment? ………………..………….☐ Yes | ☐ No

Snoring…………………………..………………….☐ Yes | ☐ No

Sleep Apnea/ CPAP…..……………………..….☐ Yes | ☐ No

GERD/ Acid Reflux..……………………………..☐ Yes | ☐ No

Recent Surgeries or medical procedures…☐ Yes | ☐ No

List all Medications you are currently taking?

What is your estimate of your dental health? ☐ Good ☐ Fair ☐ Poor

What specific dental concerns do you have now? ____

How long ago was your last visit? ____

And what was the treatment? ____

This Section for New Patients Only

Please Mark any questions that you would answer "YES"

☐ Are you here today because of an emergency/pain?
☐ Are you interested in "Comprehensive" care?
☐ Are you apprehensive about dental care?
☐ Have you had problems with previous dental treatment?
☐ Do you have a history of fainting or have dental treatment anxiety?
☐ Do you have sore, tender or bleeding gums?
☐ Have you had gingivitis or periodontal disease?
☐ Do you have your teeth cleaned more than twice a year?
☐ Have you seen a periodontal specialist for treatment?

☐ Are your teeth sensitive? And to what? (Check below)
  ☐ Hot or cold foods/liquids?
  ☐ Biting?
  ☐ Sweets?
  ☐ Other? ______________
☐ Are you missing teeth other than wisdom teeth?
☐ Do you wear partials or dentures?
☐ Do you have any dental implants?
☐ Does food catch in your teeth? Any loose teeth?

How often do you brush and floss? __________________________

Manual or electric toothbrush? __________________________

What statement best describes the treatment you are seeking?
☐Just want to avoid pain.
☐Want to keep my teeth functional and healthy.
☐Want to keep my teeth functional, healthy and looking good.

☐ Have you had orthodontics?
  ☐ Still wearing retainers?
☐Do you clench or grind your teeth frequently?
☐Do you wear a nightguard/ biteguard?
☐Do you wear a sports guard when playing sports?

☐Have you been diagnosed with a Tempormandibular (jaw) Disorder (TMJ or TMD)?
☐Do you have headaches or jaw symptoms on wakening?
☐Do you have pain in your face, jaw, neck or temples?
☐Have you had any jaw or facial trauma?

☐ Is there anything you would change about your teeth?
  ☐Color?
  ☐Shape?
  ☐Spaces?
  ☐Alignment?
  ☐Other?

Anything else we should know? ____

Signature of Patient/Responsible Party:________________________________ Date:______________________

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Do you have or have you had any of the following? Please check "YES" or "NO"