

HEALTH HISTORY

To ensure your well-being while undergoing treatment in our office, please answer the following questions in detail. All information will be considered confidential. Thank you, *David A. Sabourin, D.D.S., APC*

Date of birth: _____ Today's Date: _____

Name: _____

To the best of my knowledge all the answers on this Health History form are true and correct. If I have any change in my health or medications, I will inform the doctor at my next appointment. I further authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation. Authorization is also given for dental treatment to be rendered by the dentist and office staff; and I will assume financial responsibility.

Signature: _____

Physician's Name: _____ Physician's Phone: _____

Most recent visit to physician: _____ Reason: _____

(Please circle one)

Do we have your permission to consult with your physician? YES NO
 Are you currently seeing a physician for treatment of a recent or ongoing medical condition? YES NO

If yes, for what condition: _____

When was your last complete physical including blood tests? _____

Have you been hospitalized or had a serious illness within the last year? YES NO
 If yes, please explain: _____

Have you ever been advised to take antibiotics before a dental appointment? YES NO
 If yes, please explain: _____

Have you had any serious medical trouble associated with any dental experience? YES NO
 If yes, please explain: _____

PLEASE CIRCLE ANY PAST OR CURRENT CONDITIONS:

Jaw Joint Pain	YES	NO	Impaired Eyesight/Glaucoma	YES	NO
Arthritis	YES	NO	Hearing Aid/Hearing Disorder	YES	NO
Venereal disease	YES	NO	Kidney Condition: Shunt/Dialysis	YES	NO
Epilepsy/seizures	YES	NO	Frequent Mouth Sores or Lesions	YES	NO
Ulcers	YES	NO	Positive HIV; AIDS; AIDS related complex	YES	NO
Osteoporosis/osteopenia	YES	NO	Autoimmune disorder	YES	NO
Organ transplant	YES	NO	Parkinson's Disease	YES	NO
Depression/Anxiety	YES	NO	Drug/Alcohol addiction	YES	NO
Severe Headaches/Migraines	YES	NO	Steroid (prednisone cortisone) Therapy	YES	NO

Artificial Joint(s) YES NO
 If yes, which joints(s): _____ Date of Replacement(s): _____

Liver Condition YES NO
 If yes, circle condition(s): Jaundice; Cirrhosis; Hepatitis Type A, Type B, Type C, Non-specific

Cancer YES NO
 If yes, type: _____
 Treatment (circle all that apply) Surgical; Chemotherapy; Radiation

Endocrine:

Thyroid Disease YES NO
 Diabetes: YES NO

If yes, complete the following:
 (circle) Type I; Type II

Do you require insulin? YES NO

Your last Hemoglobin A1c: _____
 How often do you have HbA1c tested? 3mo 6mo 12mo
 How often do you check your blood sugar? _____

Circulation:

Arterio/atherosclerosis	YES	NO	Heart Surgery: (<i>circle</i>) Bypass, Valve, Other	YES	NO
High Cholesterol	YES	NO	Rheumatic Fever; Rheumatic Heart Disease	YES	NO
High/Low Blood Pressure	YES	NO	Pacemaker: If yes, date placed: _____	YES	NO
Mitral Valve Prolapse	YES	NO	Heart Attack(s): If yes, date: _____	YES	NO
Heart Murmur	YES	NO	Stroke	YES	NO
Angina (chest pain)	YES	NO	Blood/Bleeding disorder	YES	NO
Congestive Heart Failure	YES	NO	Congenital Heart Defect	YES	NO

Respiratory:

Chronic Lung Disease	YES	NO	Tuberculosis	YES	NO
Asthma	YES	NO	Ever Exposed to TB	YES	NO
Hay Fever/Allergies	YES	NO	Persistent Cough or Cough up Blood	YES	NO
Emphysema	YES	NO	Chronic Sinus	YES	NO
Current Use of Tobacco	YES	NO			
If yes, type: (<i>circle</i>) Cigarettes; Snuff/Chew; Cigar; Pipe					
If yes, How much per day? _____ Years of Use? _____					
Past history of Tobacco Use	Yes	NO	If yes, when quit? _____		

Allergies:

If allergic or have had previous reactions to the following (*Circle any/all that apply*)
 Aspirin; Penicillin; Tetracycline; Erythromycin; Sulfa; Latex; Codeine; Barbiturates;
 Tranquilizers; Dental anesthetic; Other: _____

Have you ever had an adverse reaction (nausea, dizziness, hives, rash, difficulty breathing, etc.)
 with any medicine? YES NO If yes, please explain: _____

Do you have any medical problem/condition not listed that you feel we should know about? YES NO
 If yes, explain: _____

WOMEN ONLY:

Are you currently pregnant? YES NO If yes, expected delivery date: _____

Are you nursing? YES NO Are you going or gone through menopause? YES NO

Are you currently receiving *intravenous* Bisphosphonates? YES NO
 If yes, for how long: _____

Are you currently taking *oral* Bisphosphonates (Fosamax, Actonel, Boniva)? YES NO
 If yes for how long: _____

Have you been treated with this type of medication in the past? YES NO

Herbal Medications/Supplements/Prescriptions:

Are you taking any of the following herbal medications/supplements? (*Circle any/all that apply*)

Echinacea	Licorice	Ginseng	Ephedra/Ma huang	Garlic/ajo	St. John's Wort
Ginko	Valerian	Ginger	Feverfew	Coenzyme/Q10	Goldenseal Saw Palmetto

Please list all: Prescriptions medications, herbal medications (other than indicated above) and vitamins or supplements that you are currently taking:

Name of medication:	Dosage:	Condition/Reason you are taking:
_____	_____	_____
_____	_____	_____
_____	_____	_____

DENTAL HISTORY:

Previous Dentist: _____ How long had you been a patient? _____
Date of most recent dental exam: _____ Date of most recent x-rays _____
Date of most recent treatment (other than a professional cleaning): _____
I routinely see my dentist every: _____ 3 mos _____ 4 mos _____ 6 mos _____ 12 mos _____ not routinely
What is your immediate concern? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY

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|--|-----|----|
| 1. Are you fearful of dental treatment? If yes, rank on a scale of 1 (least) to 10 (most): _____ | YES | NO |
| 2. Have you had an unfavorable dental experience? | YES | NO |
| 3. Have you ever had complications from past dental treatment? | YES | NO |
| 4. Have you ever had trouble getting numb or had any reactions to local anesthetic? | YES | NO |
| 5. Did you ever have braces, orthodontic treatment or had your bite adjusted? | YES | NO |
| 6. Have you had any teeth removed or missing teeth that never developed? | YES | NO |

GUM AND BONE

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|---|-----|----|
| 7. Do your gums bleed or are they painful when brushing or flossing? | YES | NO |
| 8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? | YES | NO |
| 9. Have you ever noticed an unpleasant taste or odor in your mouth? | YES | NO |
| 10. Is there anyone with a history of periodontal disease in your family? | YES | NO |
| 11. Have you ever experienced gum recession? | YES | NO |
| 12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? | YES | NO |
| 13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? | YES | NO |

TOOTH STRUCTURE

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|--|-----|----|
| 14. Have you had any cavities within the past 3 years? | YES | NO |
| 15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? | YES | NO |
| 16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? | YES | NO |
| 17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? | YES | NO |
| 18. Do you have grooves or notches on your teeth near the gum line? | YES | NO |
| 19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? | YES | NO |
| 20. Do you frequently get food caught between any teeth? | YES | NO |

BITE AND JAW JOINT

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|--|-----|----|
| 21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) | YES | NO |
| 22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? | YES | NO |
| 23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? | YES | NO |
| 24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? | YES | NO |
| 25. Are your teeth becoming more crooked, crowded, or overlapped? | YES | NO |
| 26. Are your teeth developing spaces or becoming looser? | YES | NO |
| 27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? | YES | NO |
| 28. Do you place your tongue between your teeth or close your teeth against your tongue? | YES | NO |
| 29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? | YES | NO |
| 30. Do you clench your teeth in the daytime or make them sore? | YES | NO |
| 31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? | YES | NO |
| 32. Do you wear or have you ever worn a bite appliance? | YES | NO |

SMILE CHARACTERISTICS

- | | | |
|---|-----|----|
| 33. Is there anything about the appearance of your teeth that you would like to change? | YES | NO |
| 34. Have you ever whitened (bleached) your teeth professionally? | YES | NO |
| 35. Have you felt uncomfortable or self-conscious about the appearance of your teeth? | YES | NO |
| 36. Have you been disappointed with the appearance of previous dental work? | YES | NO |