MEDICAL HEALTH HISTORY:

Do you have, or have you had, any of the following?

	Yes	No
Heart Problems	☐	☐
High or low blood pressure	☐	☐
Shortness of breath	☐	☐
Heart murmur	☐	☐
Heart valve problem	☐	☐
Taking heart medication	☐	☐
Rheumatic fever	☐	☐
Pacemaker	☐	☐
Artificial heart valve	☐	☐
Blood Problems	☐	☐
Easy bruising	☐	☐
Frequent nosebleeds	☐	☐
Abnormal bleeding	☐	☐
Blood disease (anemia)	☐	☐
Ever require a blood transfusion?	☐	☐
Intestinal Problems	☐	☐
Ulcers	☐	☐
Weight gain or loss	☐	☐
Kidney or bladder problems	☐	☐
Bone or Joint Problems	☐	☐
Arthritis	☐	☐
Back or neck pain	☐	☐
Joint replacement	☐	☐
Osteoporosis	☐	☐
Medication required?	☐	☐
Fainting Spells, Seizures, or Epilepsy	☐	☐
Medication required?	☐	☐
Thyroid problems	☐	☐
Medication required?	☐	☐
Persistent cough or swollen glands	☐	☐
Diabetes	☐	☐
Thirsty or frequent dry mouth	☐	☐
Family history of diabetes	☐	☐
Glaucoma	☐	☐
Hepatitis, jaundice or liver trouble	☐	☐
Tuberculosis or other respiratory disease	☐	☐
Cancer/Tumor	☐	☐
HPV testing or vaccine?	☐	☐

Treatment history: _____

	Yes	No
Allergy Problems	☐	☐
Sinus problems	☐	☐
Taking allergy medications	☐	☐
Asthma	☐	☐
Do you consume alcohol?	☐	☐
Do you use tobacco?	☐	☐
History of cold sores or herpes	☐	☐
HIV-positive	☐	☐
Do you wear contact lenses?	☐	☐
History of alcohol or drug abuse?	☐	☐
Premedication required by physician	☐	☐

Do you have any disease, condition, or problem not listed previously that you feel we should know about?

If so, please describe: _____

Are you allergic, or have you reacted adversely, to any of the following?	Yes	No
Local anesthetics ("Novocaine")	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex or rubber dam	☐	☐
Other:_____		

Current medication list and reason you are taking:

_____

_____

Women	Yes	No
Are you taking contraceptives or other hormones?	☐	☐
Are you or could you be pregnant?	☐	☐
If so, expected due date: _____		

Print Name: _____

Patient Signature: _____

Dentist Initial: _____

SAFE HARBOR DENTAL

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, do not hesitate to ask.

Patient name: _____ Date of birth: _____ Sex: _____ Age: _____

Home address: _____ City: _____ State: _____ Zip:_____

Billing address (if different): _____ City: _____ State: _____ Zip:_____

Home phone: _____ Cell: _____ E-mail: _____

Employer/Occupation: _____ Bus. Phone: _____

Spouse's name & phone #: _____ Occupation:_____

Emergency name (other than spouse): _____ Phone #:_____

Primary dental insurance: _____ Group #:_____

Secondary dental insurance: _____ Group #:_____

Subscriber's name: _____ Date of birth:_____ SS #:_____

Name and # of your medical doctor: _____ Last visit: _____

Name of previous dentist: _____ Last visit: _____

How did you hear about our office: _____

DENTAL HEALTH HISTORY

	Yes	No
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty in chewing your food?	☐	☐
Do you chew on only one side of your mouth?	☐	☐
Do you avoid brushing any part of your mouth because of pain?	☐	☐
Have you ever noticed cold sores in or about your mouth?	☐	☐
Do you have a history of sleep apnea?	☐	☐
If yes, do you use a CPAP or appliance?	☐	☐
Do your gums bleed easily	☐	☐
Are your teeth sensitive?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Would you like your teeth to be whiter?	☐	☐
Do you or have you been told you snore?	☐	☐
Do you want complete dental care?	☐	☐
How often do you brush? _____		
How often do you floss? _____		
Do you use other aids?	☐	☐
Do you have any history of jaw discomfort?	☐	☐