NAME:

DATE OF BIRTH:

PATIENT HEALTH HISTORY FORM

GREGORY D. MARTIN, DDS, PC

Are you currently experiencing dental problems? Yes or No

If yes, please explain:

Emergency Contact:

Emergency Phone #:

MEDICAL HISTORY

Do you have a primary care physician? Yes or No

If Yes, what is the Physicians name?

Phone #: **Last visit date:**

Your current physical health is: *(Please Circle)* Good Fair Poor

Are you currently under the care of a physician? Yes or No

Please explain:

Are you taking any prescription medication? Yes or No

Please list:

Are you taking any over-the-counter drugs or vitamins? Yes or No

Please list:

Women: Are you taking birth control pills? Yes or No

Are you pregnant? Yes or No If yes, what is the due date?

Have you ever had any of the following diseases or medical problems?
(Please Circle Y for yes or N for no)

Y	N	Abnormal Bleeding	Y	N	Epilepsy		
Y	N	Anemia	Y	N	Fainting Spells		
Y	N	Artificial Joints/Valves	Y	N	Frequent Headaches		
Y	N	Congenital Heart Defect	Y	N	Glaucoma		
Y	N	Heart Attack/Surgery	Y	N	Hepatitis/Any Form		
Y	N	Heart Murmur	Y	N	Herpes/Fever Blisters		
Y	N	Alcohol/Drug Abuse	Y	N	HIV/AIDS		
Y	N	Hemophilia	Y	N	Hospitalized/Any Reason		
Y	N	High Blood Pressure	Y	N	Kidney Problems		
Y	N	Low Blood Pressure	Y	N	Liver Disease		
Y	N	Mitral Valve Prolapse	Y	N	Osteoporosis		
Y	N	Pacemaker	Y	N	Radiation Treatment		
Y	N	Allergies	Y	N	Rheumatic/Scarlet Fever		
Y	N	Arthritis	Y	N	Seizures		
Y	N	Asthma	Y	N	Sickle Cell Disease		
Y	N	Blood Transfusion	Y	N	Sinus Problems		
Y	N	Breathing Problems	Y	N	Stroke		
Y	N	Cancer/Chemotherapy	Y	N	Thyroid		
Y	N	Chest Pain	Y	N	Tuberculosis (TB)		
Y	N	Diabetes	Y	N	Ulcers		

Please list serious medical condition(s) that you have ever been treated for:

DENTAL HISTORY

Who/where was your previous dentist?

City: **State:**

Last dental exam date:

Last X-rays Date:

Have you ever had a serious/difficult problem associated with any dental work? Yes or No

If yes, please explain:

Do you require antibiotics before dental treatments? Yes or No

NOTE: Oral antibiotics may interfere with the effectiveness of oral contraceptives.

How often do you brush? _____ times per day

How often do you floss? _____ times per day

Are your teeth sensitive to heat or cold?	Y	N	Do you use mouth rinse or fluoride gels?	Y	N
Do you smoke or use tobacco in any form?	Y	N	Have you worn braces or a retainer?	Y	N
Do your gums bleed?	Y	N	Do you use toothpicks or proxabrush?	Y	N
Have you ever had periodontal disease?	Y	N	Can we take a photograph for our records?	Y	N
Have you ever had gum treatments?	Y	N	Would you like an Oral Cancer Screening Test?	Y	N
Does food catch between your teeth?	Y	N	Are you happy with the way your smile looks?	Y	N
Do you clench or grind your teeth?	Y	N			
Do you now or have you ever had pain in your jaw joint (TMJ/TMD)?	Y	N			
Do you have clicking or popping of your jaws?	Y	N			
Do you have dental implants?	Y	N			
Do you wear partials or dentures?	Y	N			
Do you snore?	Y	N			
Do you have dry mouth?	Y	N			
Do you have mouth ulcers or fever blisters?	Y	N			

If not, what would you change?

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N Penicillin
Y	N	Codeine	Y	N	Jewelry/Metals	Y	N Sulphur
Y	N	Dental Anesthetics	Y	N	Latex		

I affirm that to the best of my knowledge the information provided is accurate and complete. Any changes in my health status or medications will be reported to the Doctor at the next visit following the change. In addition, I authorize the Doctor or his representative to take radiographs, study models, or photographs deemed appropriate to make a thorough diagnosis and to develop proper treatment recommendations.

SIGNATURE: **DATE:**