Ron Freeman, D.D.S.
HEALTH HISTORY QUESTIONNAIRE

Patient Name _____

Welcome to our Office. We are a health-centered dental practice, thus we are concerned with our total well-being, not just your oral health. An essential part of our approach is a thorough health history. Please fill out the health questionnaire below completely -- even if some of the questions may not seem relevant to your dental health. Thank you!

Chief Oral complaint: _____Date of last Dental exam: _____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING? (INDICATE WITH A ❑).

Yes	No	
❑	❑	Teeth sensitive to cold, heat, sweets or pressure
❑	❑	Bleeding gums. How long _____
❑	❑	Food impaction
❑	❑	Clenching or grinding
❑	❑	Swelling or lumps in mouth
❑	❑	Frequent blisters on lips or mouth
❑	❑	Pain around ear
❑	❑	Unusual sounds in ear while eating
❑	❑	Unfavorable dental experience
❑	❑	Complications from extractions
❑	❑	Periodontal treatment

Yes	No	
❑	❑	Orthodontic treatment
❑	❑	Mouth breathing
❑	❑	Oral habits (fingernail biting, cheek biting, etc.)
❑	❑	Inter dental stimulators
❑	❑	Water jet devices
❑	❑	Fluoride supplements
❑	❑	Thumb Sucking

Texture of toothbrush _____

Frequency of brushing _____

Dental floss frequency _____

Is patient allergic to any medications? ❑ Yes ❑ No List: _____

Have you had unfavorable reactions to any of the following? (Indicate with a ❑).

Yes	No		Yes	No		Yes	No		Yes	No	
❑	❑	Anesthetics	❑	❑	Codeine	❑	❑	Sedatives	❑	❑	Other Antibiotics
❑	❑	Penicillin	❑	❑	Aspirin	❑	❑	Latex	❑	❑	Other Drugs

Please list any drugs currently being taken and any current medical treatments _____

_____

_____

Physician's Name _____ Phone No. _____ Date of Last Physical Exam _____

How would you rate your overall health ❑ Poor ❑ Fair ❑ Good ❑ Excellent

Do you have any systemic illness we should be aware of? ❑ Yes ❑ No

PLEASE INDICATE ACCORDINGLY (WITH A ❑).

Yes	No		Yes	No		Yes	No	
❑	❑	Heart Attack or Heart Trouble	❑	❑	Blood Transfusions	❑	❑	Epilepsy, Seizures
❑	❑	High Blood Pressure	❑	❑	Anemia, Blood Disorder	❑	❑	Facial or Head Injuries
❑	❑	Stroke	❑	❑	Sinus Problems, Tonsillitis	❑	❑	Fainting, Blackouts
❑	❑	Heart Murmur	❑	❑	Hay Fever, Asthma, Allergies	❑	❑	Kidney Problems
❑	❑	Rheumatic Fever	❑	❑	Headaches, Migraines	❑	❑	Diabetes
❑	❑	Hip Replacement, Pins, Plates	❑	❑	Eye Problems/Glaucoma	❑	❑	Circulatory Problems
❑	❑	Antibiotic Pre-Med	❑	❑	Lung Problems, Tuberculosis	❑	❑	Psychiatric Care/Emotional Problems
❑	❑	Mitro Valve Prolapse	❑	❑	Radiation Treatments	❑	❑	Are you Pregnant Now?
❑	❑	Hepatitis, Liver Problems	❑	❑	Malignancies, Cancer	❑	❑	Cigarettes/cigar smoking or chewing tobacco
❑	❑	Excessive Bleeding	❑	❑	Ulcers, Digestive Problems	❑	❑	HIV / AIDS

Medical History Update _____

_____

The information above is correct to the best of my knowledge. I give my consent to have the necessary treatment recommended for my benefit (or my minor) only after it has been mutually approved.

Date _____ Signature _____

Updated _____ Signature _____