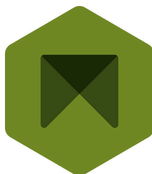


SHAPIRO DENTAL

Today's Date:________________

Patient Health History

Thank you for filling out an updated Health History form every three years. This is for legal purposes and we appreciate your time. Accurate information and medication list are of utmost importance so we can treat you appropriately in the dental office.

General Health History

Patient Name:______________________________ DOB:______________________________

Physician's Name:______________________________ Office Number:______________________________

Are you under care now? ☐YES ☐NO If yes, please explain: ______________________________

Have you been hospitalized or had a major operation? ☐YES ☐NO If yes, please explain: ______________________________

Are you taking any medication including (but not limited to) any *blood thinners*(Coumadin, Warfarin, Xarelto, Plavix, etc), taken medications for *osteoporosis, previous cancers or Paget's disease* (Fosamax, Boniva, Actonel, Reclast, Prolia)? (please fill out medication list form)
☐YES ☐NO

Are you taking and IV medication to treat bone conditions (Xgeva, Aredia, Zometa): ☐YES ☐NO

Do you use tobacco? ☐YES ☐NO Do you use controlled substances?☐YES ☐NO

Are you allergic to any of the following?

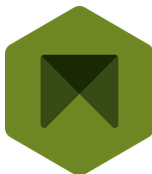
☐Aspirin ☐Amoxicillin ☐Codeine ☐Local Anesthetics ☐Latex ☐Sulfa Drugs ☐Penicillin ☐Acrylic

☐none Other:______________________________

WOMEN Are you pregnant?☐YES ☐NO Nursing?:☐YES ☐NO

Do you have, or have you had, any of the following? (circle any that apply)

Anemia	Chemical Dependency	Headaches	Pacemaker	Swelling of Feet/Ankles
Artificial Heart Valves	**Chemotherapy**	Heart Murmur	**Radiation Treatment**	Thyroid Problems
Artificial Joints	Congenital Heart Defect	Hemophilia	Respiratory Disease	Tonsillitis
Asthma	Cough, Persistent	Hepatitis	Rheumatic Fever	Tuberculosis
Autoimmune Disease	**Diabetes**	**High Blood Pressure**	**Rheumatoid Arthritis**	Ulcers
Back Problems	Eating Disorder	HIV/AIDS	Shortness of Breath	Venereal Disease (STD)
Bleeding Abnormality	Epilepsy	Kidney Disease	Skin Rash	**OTHER:**
Blood Disease	Fainting	Liver Disease	Steroid Treatments	
Cancer	Glaucoma	**Osteoporosis**	**Stroke**	



SHAPIRO DENTAL

Today's Date:________________

Dental History

Last Dental Visit:____________ Last Dental Cleaning:___________ Last Full Mouth X-Rays:___________

Previous Dentist Name:________________________________ Telephone:______________________

How often do you have dental exams?:____

How often do you brush your teeth?:____________________________ Floss?___________________

What other dental aids do you use (Electric toothbrush, Waterpik, etc.)?:_______________________

Do you have any dental problems now? ☐YES ☐NO

If yes, please describe:____

Are you required to take premedication prior to dental treatment? ☐YES ☐NO

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

Are any of your teeth sensitive to:

- Hot or cold? . . . . ☐YES ☐ NO
- Sweets?. . . . . ☐YES ☐ NO
- Biting or chewing? . . . . ☐YES ☐ NO

Have you noticed any mouth odors or bad taste? . . . . ☐YES ☐ NO

Do you frequently get cold sores, blisters or any other oral lesions? . . . . ☐YES ☐ NO

Do your gums bleed or hurt? . . . . ☐YES ☐ NO

Have you noticed any loose teeth or change in your bite?. . . . . ☐YES ☐ NO

Does food tend to become caught in between your teeth? . . . . ☐YES ☐ NO

If yes, where?

____

Do you:

Clench or grind your teeth while awake or asleep?. . . . . ☐YES ☐ NO

Bite your lips or cheeks regularly? . . . . ☐YES ☐ NO

Mouth breathe while awake or asleep? . . . . . ☐YES ☐ NO

Have tired jaws, especially in the morning? . . ☐YES ☐ NO

Snore or have any other sleeping disorders? . ☐YES ☐ NO

Have you ever had:

- Orthodontic treatment? . . . . ☐YES ☐ NO
- Oral surgery? . . . . ☐YES ☐ NO
- Periodontal treatment? . . . . ☐YES ☐ NO
- Your teeth ground or the bite adjusted?. . . . . ☐YES ☐ NO
- A bite plate or mouth guard? . . . . . ☐YES ☐ NO
- A serious injury to the mouth or head? . . . . ☐YES ☐ NO

If yes, please describe, including cause

____

Have you experienced:

Clicking or popping of the jaw? . . . . ☐YES ☐ NO

Difficulty in opening or closing the mouth? . . . ☐YES ☐ NO

Difficulty in chewing on either side of the mouth?. . . . . ☐YES ☐ NO

Are you satisfied with your teeth's appearance?. . . . . ☐YES ☐ NO

Would you like to keep all of your teeth all of your life? . . . . ☐YES ☐ NO

Do you feel nervous about having dental treatment? . . . . ☐YES ☐ NO

If so, what is your biggest concern?

____

Have you ever had an upsetting dental experience?
☐YES ☐NO If yes, please explain: ____________________

____

Patient (Guardian) Signature: ____________________________________ **Date:** ________________

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