David J. Wright, DDS
www.doctordavewright.com

Name _____ **Date of Birth**_____

To provide you with the best treatment and safest possible care, please take a moment to fill out this health form.

Physician _____

Tel #

_____

Pharmacy, tel #

Do you presently, or have ever had:

Yes No

- ☐ ☐ Tooth sensitivity
- ☐ ☐ Are you unhappy with your smile
- ☐ ☐ Bad breath
- ☐ ☐ Mouth breather
- ☐ ☐ Dry mouth
- ☐ ☐ Bleeding/ tender gums
- ☐ ☐ Gum treatment or surgery
- ☐ ☐ Cold sores/ blisters in mouth
- ☐ ☐ Orthodontics (braces)
- ☐ ☐ Pregnant right now?
- ☐ ☐ Glaucoma
- ☐ ☐ Congenital heart condition
- ☐ ☐ Infective endocarditis
- ☐ ☐ Artificial heart valve/ pacemaker
- ☐ ☐ Cardiac transplant with valve problem
- ☐ ☐ Blood disorders (anemia, leukemia, etc.)
- ☐ ☐ Bleeding abnormally with tooth extractions/ surgery
- ☐ ☐ High/low blood pressure
- ☐ ☐ Serious illness/major surgery
- ☐ ☐ Radiation/chemo treatment
- ☐ ☐ Cancer
- ☐ ☐ Inflammatory diseases (arthritis/rheumatism)

Yes No

- ☐ ☐ Artificial joints/ prosthesis
- ☐ ☐ HIV / AIDS
- ☐ ☐ Hepatitis Type ___
- ☐ ☐ Stomach/ digestion problems
- ☐ ☐ Kidney problems
- ☐ ☐ Liver problems
- ☐ ☐ Back problems
- ☐ ☐ Diabetes
- ☐ ☐ Stroke
- ☐ ☐ Nervous disorder (cerebral palsy, etc.)
- ☐ ☐ Mental disorder
- ☐ ☐ Seizures
- ☐ ☐ Fainting/dizzy spells
- ☐ ☐ Epilepsy
- ☐ ☐ Respiratory problems
- ☐ ☐ Asthma
- ☐ ☐ Emphysema
- ☐ ☐ Tuberculosis (TB)
- ☐ ☐ Smoke/ chew/ snuff tobacco
- ☐ ☐ Recreational Drug Usage
- ☐ ☐ Drug/ alcohol problems
- ☐ ☐ Head or whiplash injury
- ☐ ☐ Sinus trouble/ pain
- ☐ ☐ Clench/Grind teeth
- ☐ ☐ Clicking/popping of jaw
- ☐ ☐ Pain/soreness in the muscles of your jaw/ face/ around ear/ neck/ shoulders
- ☐ ☐ Headaches or migraines

Yes No

- ☐ ☐ Snoring
- ☐ ☐ Jaw gets stuck open or closed
- ☐ ☐ Limited opening of your jaw
- ☐ ☐ Jaw goes to one side when opening
- ☐ ☐ Pain or difficulty when chewing
- ☐ ☐ Difficulty swallowing
- ☐ ☐ Ear stuffiness
- ☐ ☐ Ringing in the ears
- ☐ ☐ Pain or pressure behind eyes
- ☐ ☐ Under physician's care
- ☐ ☐ Taking any medications/ supplements (**please list** below)
- ☐ ☐ Taking any Bisphosphonates (Actonel, Fosamax, Boniva)
- ☐ ☐ **Allergies** to medications/ substances (penicillin, codeine, amoxicillin, aspirin, erythromycin, latex)
- ☐ ☐ Sensitivity to latex or metals
- ☐ ☐ Have you been told to take antibiotics before dental visits? (see changes 4/07)
- ☐ ☐ **Is there anything else we should know about your health?**

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE. *I also certify that I have received the Dental Materials Fact Sheet and the Privacy Notice.*

PATIENT/GUARDIAN DATE

DENTIST SIGNATURE DATE

***Medications currently taking*:**

NOTES:

Health History Updates:
Date:

HEALTH HISTORY (rev 5/09)