Apex Dental, P.C.

HEALTH HISTORY

Patient Name: _____ Birth Date: _____ Date Created: _____

Disclaimer

Health conditions that you may have, or medications you may be taking, can have an important interrelationship with the dentistry that you may be receiving. Please complete thoroughly.

General Questions

Do you have a PCP? List their name and date of last exam:	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Have you ever been diagnosed with cancer?	Yes No	If yes
Do you use tobacco or any recreational drugs (e.g. smoke, chew, vape, etc.)?	Yes No	If yes
Have you ever taken any bisphosphonates (e.g. Fosamax, Boniva, Actonel, Zometa, Reclast, etc.)?	Yes No	

Please list all current medications or supplements (prescription and OTC):

Women Only

Are you:

☐ Pregnant/May be pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Allergies

Do you have any of the following allergies?

Aspirin	Yes No	Codeine	Yes No	Metal	Yes No	Latex	Yes No
Sulfa Drugs	Yes No	Local Anesthetics	Yes No	Iodine	Yes No	Sedatives	Yes No
Seasonal	Yes No	Penicillin	Yes No				

Other allergies (e.g. Medication, food, etc.)? Yes No If yes

Health Conditions

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

AIDS/HIV Positive	Yes No	Developmental Disorder	Yes No	Kidney Problems	Yes No	Thyroid Disease	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Liver Disease	Yes No	Tuberculosis	Yes No
Amyotrophic Lateral Sclerosis (ALS)	Yes No	Drug Addiction	Yes No	Low Blood Pressure	Yes No	Tumors or Growths	Yes No
Anaphylaxis	Yes No	Emphysema/COPD	Yes No	Multiple Sclerosis	Yes No	Frequent Headaches	Yes No
Anemia	Yes No	Epilepsy or Seizures	Yes No	Muscular Dystrophy	Yes No	Pain in Jaw Joints	Yes No
Angina	Yes No	Excessive Bleeding	Yes No	Osteoporosis	Yes No	Clicking/Popping of Jaw	Yes No
Anxiety	Yes No	Fainting Spells/Dizziness	Yes No	Parkinson's Disease	Yes No	Jaw Locking	Yes No
Artificial Heart Valve	Yes No	Heart Attack	Yes No	Psychiatric Care	Yes No	Sore Neck/Shoulders	Yes No
Artificial Joint	Yes No	Heart Disease	Yes No	Radiation Treatments	Yes No	Clenching/Grinding	Yes No
Asthma	Yes No	Heart Failure	Yes No	Renal Dialysis	Yes No	Difficulty Chewing	Yes No
Autoimmune Disease	Yes No	Heart Pacemaker	Yes No	Shingles	Yes No	Broken Teeth	Yes No
Bruise Easily	Yes No	Hemophilia	Yes No	Sickle Cell Disease	Yes No	Pain Around Eyes	Yes No
Chemotherapy	Yes No	Hepatitis	Yes No	Sinus Trouble	Yes No	Pain in Temple Region	Yes No
Cold Sores/Fever Blisters	Yes No	High Blood Pressure	Yes No	Stomach/Intestinal Disease	Yes No	Earache	Yes No
Congenital Heart Disorder	Yes No	High Cholesterol	Yes No	Stroke	Yes No	Ringing In Ears	Yes No
Depression	Yes No	Irregular Heartbeat	Yes No	Swelling of Limbs	Yes No		

Have you ever had any other serious conditions not listed? Yes No If yes

Dental

History and Concerns

Gums bleed while brushing or flossing?	Yes No	Tooth pain?	Yes No	Sores or lumps in or out of the mouth?	Yes No
Sensitivity to hot/cold?	Yes No	Previously had braces?	Yes No	Do you have dental anxiety?	Yes No
Do you experience dry mouth?	Yes No	Is fluoride taken in any form?	Yes No	Mouth habits: nail biting, thumb sucking?	Yes No
Do you currently use a mouth guard?	Yes No	Do you use an electric toothbrush?	Yes No	Prolonged bleeding post dental procedure?	Yes No

Are you brushing daily? How often?	Yes No	If yes
Are you flossing? How often?	Yes No	If yes
Is there anything you'd like to change about your smile?	Yes No	If yes

I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____

Clinician Notes

Signature of Doctor:

X Date:_____