

CRAIG E. PEARCE, D.M.D.

We are a health-centered dental practice; thus we are concerned with your 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.

MEDICAL HISTORY

Name & Phone Number of Physician _____ Last Physical Exam _____

Are you receiving any health care now? Yes___ No___ For what purpose? _____

Are you taking any medications? Yes___ No___ For what purpose? _____

Please list medications: _____

HAVE YOU HAD OR DO YOU HAVE:

| | | | | | |
|---|--------------|--------------------------|--------------|-------------------------|--------------|
| AIDS (Acquired Immune Deficiency Syndrome) | Yes___ No___ | Epilepsy | Yes___ No___ | STD | Yes___ No___ |
| Allergies: | | Glaucoma | Yes___ No___ | Heart Conditions: | |
| Penicillin | Yes___ No___ | Hearing Impaired | Yes___ No___ | Abnormal Blood Pressure | Yes___ No___ |
| Local Anesthetic | Yes___ No___ | Hepatitis | Yes___ No___ | Artificial Valve | Yes___ No___ |
| Codeine | Yes___ No___ | Hip or joint replacement | Yes___ No___ | Heart Attack | Yes___ No___ |
| Other _____ | | Kidney Dialysis | Yes___ No___ | Heart Murmur | Yes___ No___ |
| Anemia | Yes___ No___ | Oral Herpes | Yes___ No___ | Stroke | Yes___ No___ |
| Asthma | Yes___ No___ | Prolonged bleeding | Yes___ No___ | Mitral Valve Prolapse | Yes___ No___ |
| Blood Transfusion | Yes___ No___ | Pacemaker | Yes___ No___ | Women: | |
| Chemotherapy | Yes___ No___ | Rheumatic Fever | Yes___ No___ | Are you pregnant? | Yes___ No___ |
| Diabetes | Yes___ No___ | Serious Accident | Yes___ No___ | | |
| Drug/Alcohol Dependency | Yes___ No___ | Sinus Problems | Yes___ No___ | | |
| Do you use tobacco products? | Yes___ No___ | | | | |
| Any other medical condition we should know about? _____ | | | | | |

DENTAL HISTORY

DATE OF LAST DENTAL VISIT _____ PREVIOUS DENTIST _____

Purpose of Today's Appointment _____

Do you like the appearance of your teeth? Yes___ No___ What would you change? _____

Have you had orthodontic treatment? Yes___ No___ Dates of Treatment _____

Have you been treated for Periodontal (gum) disease? Yes___ No___ When? _____ By whom? _____

Are you aware of any clenching or grinding of your teeth? Yes___ No___

Do you have any pain or clicking upon opening or closing your jaw? Yes___ No___

Do you wear full or partial dentures?

Last Full Mouth X-Rays? Date: _____

HAVE YOU NOTICED ANY OF THE FOLLOWING?

Discomfort when chewing Yes___ No___ Recurring sore in or around the mouth Yes___ No___

Discomfort in face, head or neck Yes___ No___ Sensitivity to hot or cold Yes___ No___

Food caught between teeth Yes___ No___ Swelling, lumps in mouth Yes___ No___

Bleeding or sore gums Yes___ No___ Sensitivity to sweets Yes___ No___

Have you had any problems with previous dental treatment? Yes___ No___ Please explain: _____

MEDICAL HISTORY UPDATE

| DATE | CHANGE | PATIENT SIGNATURE |
|------|--------|-------------------|
| | | |
| | | |
| | | |

CONSENT FOR TREATMENT: I hereby grant Dr. Craig Pearce and/or his staff in charge of the patient whose name appears on this health history form, to administer any treatment and such x-rays, anesthetics and/or nitrous oxide sedation, and to perform such operations as may be deemed necessary or advisable in the treatment of this patient.

Signed _____ Date _____ Relationship to Patient _____