JEREMY ARCHIBALD DDS
FAMILY & COSMETIC DENTISTRY

Patient Health History

Patient's Name _____ Today's Date _____
Date of Birth _____

Please rate your health. □ **Excellent** □ **Very Good** □ **Good** □ **Fair** □ **Poor**

Has there been a change in your general health in the past year? □ **Yes** □ **No**
If so please explain:_____

Are you currently under treatment by a physician? □ **Yes** □ **No**
Name primary care physician _____ Date of last MD visit _____

Have you been hospitalized for a serious illness or injury during the last five years?
If so please explain: _____
_____

Have you experienced an allergic or unusual reaction to any of the following? □ **NO**

□ **Penicillins**	□ **Opiates/Codeine**	□ **Other drugs or substances:**
□ **Sulfa drugs**	□ **Latex**	**List: 1. _____**
□ **Aspirin**	□ **Local Anesthetics**	**2. _____**
		3. _____

Please list all prescription/non-prescription medications (including vitamins and herbal medications) that you regularly take (Please provide list if space is inadequate)
_____
_____

Do you use tobacco? □ **Yes** □ **No** **Do you vape?** □ **Yes** □ **No**
How often/what form _____ **Do you smoke marijuana** □ **Yes** □ **No**

Have you ever taken Fosamax, Boniva, Actonel, Zometa, Reclast or any other medication containing bisphosphonates? □ **Yes** □ **No**

***Women, are you** □ **Pregnant** □ **Trying to get Pregnant** □ **Nursing**

Mark any conditions or symptoms that you NOW experience or HAVE previously experienced.

□ **High Blood Pressure**	□ **High Cholesterol**	□ **Ulcers/Irritable Bowel**
□ **Heart Attack**	□ **Diabetes (**Type_____**)**	□ **Reflux/Frequent Heartburn**
□ **Angina (chest pain)**	□ **Autoimmune disorder**	□ **Epilepsy or Seizure Disorder**
□ **Stroke**	□ **Thyroid Disease**	□ **Alzheimer's Disease/Dementia**
□ **Pacemaker**	□ **Arthritis/Gout**	□ **Autism Spectrum Disorder**
□ **Heart Valve Disease**	□ **Skin Disorders**	□ **Mental Illness**
□ **Irregular Heartbeat**	□ **Kidney Disease**	□ **Neurologic Disorders**
□ **Congestive Heart Failure**	□ **Liver Disease**	□ **Anxiety/Depression**

□ **Asthma/Shortness of Breath**
□ **Emphysema/Bronchitis**
□ **COPD**
□ **Anemia**
□ **Bleed or Bruise Easily**
□ **Tuberculosis**
□ **Sexually Transmitted Disease**
□ **Herpes Infection (Cold Sores)**
□ **Hepatitis:** Type_____
□ **Tuberculosis**
□ **HIV**
□ **Cancer:** Type_____
□ **Radiation/chemotherapy**
□ **Organ Transplant:_____**
□ **Frequent Headaches**
□ **Drug/Alcohol Abuse**
□ **Hay Fever/Seasonal Allergies**
□ **Chronic Pain**
□ **Prosthetic Joint/Implant**
Explain_____

Do you have any diseases or conditions not mentioned above? _____
_____
_____

Dental History

Do your gums bleed while brushing or flossing?	□ **Yes**	□ **No**
How many times each day do you brush? _____ **Type of brush_____**		
How many times a week do you floss?_____		
Do you have any teeth that are difficult to floss?	□ **Yes**	□ **No**
List any mouthrinses or other oral hygiene aids you use? _____		
Are your teeth sensitive to hot/cold liquids or food?	□ **Yes**	□ **No**
Are your teeth sensitive to sour or sweet foods?	□ **Yes**	□ **No**
Do you have any sores or lumps in/around your mouth?	□ **Yes**	□ **No**
Do you experience a chronic dry mouth?	□ **Yes**	□ **No**
Have you experienced any of the following?		
Clicking, popping, noise in your jaw joints	□ **Yes**	□ **No**
Pain in joint, ear, or side of face	□ **Yes**	□ **No**
Difficulty opening or closing your mouth	□ **Yes**	□ **No**
Do you have a difficult time chewing your food?	□ **Yes**	□ **No**
Have you had orthodontic treatment (braces)?	□ **Yes**	□ **No**
Have you ever received treatment for periodontal disease (deep cleanings, gum surgeries, etc.)?	□ **Yes**	□ **No**
Do you wear a complete or partial denture?	□ **Yes**	□ **No**
Have you ever had dental implants?	□ **Yes**	□ **No**
Have you ever had difficulty with any previous dental treatment? Please Explain_____	□ **Yes**	□ **No**
Are you apprehensive about receiving dental care?	□ **Yes**	□ **No**

What has worked well in the past to manage your anxiety?_____

What would like to change about your smile or your dental health?

_____

_____

Patient's Signature_____ Date_____

Reviewed by _____ Date_____