Virginia H. Ellis, DDS
Dental Corp.
Family and Cosmetic Dentistry

Confidential Health History

Name:_____ DOB:_____ Today's Date:_____

Are there any areas in your mouth that you would like to improve/change?

Do you have any questions or concerns?

Caries (tooth decay):

Do you consider yourself cavity prone?.....Y N

Do you consume sugary foods regularly?.....Y N

Do you consume energy drinks or sports drinks?.....Y N
If yes, what type and how often?

Does your mouth feel dry?.....Y N

Do you have heartburn or acid reflux?.....Y N

Periodontal Disease:

Have you been told you have gingivitis or gum disease?.....Y N

Do your gums ever bleed when you brush or floss?.....Y N

Do you have gum recession or exposed root surfaces?.....Y N

Do you have any loose teeth or areas that collect food when you eat?.....Y N

Oral Medicine:

Do you take over the counter medicines?.....Y N

Do you have any persistent sores in your mouth or lumps/bumps on your head or neck?.....Y N

Do you feel as if you have a lump in your throat?.....Y N

Do you ever get cold sores?.....Y N

Medical Care:

Are you currently being treated for any medical conditions?.....Y N
If yes, please list:

Do you get annual medical check-ups?.....Y N

Do you see a dermatologist for an annual skin cancer screening?.....Y N

Function/Bite/TMJ:

Do you ever experience discomfort when chewing?....Y N

Do your jaw joints click, lock, pop or make grinding sounds?.....Y N

Do you experience frequent headaches or jaw/facial pain?.....Y N

Have you ever been told that you grind your teeth?...Y N

Have you been treated for a jaw joint problem?.....Y N

Do you wear a retainer or night guard?.....Y N

Cancer:

Do you have a cancer diagnosis or history?.....Y N

Are you undergoing cancer treatment?.....Y N

Pre-Diabetes and Diabetes

Have you ever been diagnosed with pre-diabetes or diabetes?.....Y N

If so, what type?.....I II

Do you take medication(s) for diabetes, hypertension or high cholesterol?.....Y N
Please list medications:

Medical Conditions:

Do you have or have had any of the following? Please circle:

Anaphylaxis	**Hearing disorder**
Anemia	**Hives/skin rash**
Anxiety	**Kidney problems**
Artificial joints	**Liver problems**
Blood disease	**Lung disease**
Blood transfusion	**Pacemaker**
Congenital heart defect	**Psychiatric problems**
Endocrine problems	**Seizures/Epilepsy**
Heart murmur	**Sinus problems**
Hepatitis A, B or C	**Thyroid disease**
Herpes	**Tuberculosis**
HIV/AIDS	**Tumor or growth of head/neck**

OTHER:

Virginia H. Ellis, DDS
Dental Corp.
Family and Cosmetic Dentistry

Brain/Organ Health:

Have you been diagnosed with dementia, Alzheimer's or any other brain function ailment?.....Y N
If yes, please specify condition:

Are you aware of or being treated for any vital organ disease?.....Y N
If yes, please list:

Habits:

Do you smoke or chew tobacco?.....Y N
If so, how often/how much:

Do you use cocaine or other drugs?.....Y N

Do you consume alcohol?.....Y N

Are you in recovery or being treated for addiction?.....Y N

Allergies, Food Sensitivities:

Do you have asthma?.....Y N

Do you use an inhaler?.....Y N

Have you identified any food sensitivities such as dairy, wheat or soy?.....Y N

Do you ever have heartburn?.....Y N

Are you allergic to any of the following? Please circle:

Latex Aspirin Codeine Tetracycline Valium Metals Sulfa Drugs Novocaine/Local anesthetic Nitrous Oxide Penicillin/Antibiotics Erythromycin Vicodin Percodan

Other:

Exercise/Sleep:

Do you exercise regularly?.....Y N

Do you snore or have difficulty sleeping?.....Y N

Bone/Joint Health:

Have you had joint replacement surgery?.....Y N
If yes, please specify:

Have you taken antibiotics for dental appointments as a result of joint replacement?.....Y N

Have you been diagnosed with Osteopenia or Osteoporosis?.....Y N

Are you currently taking or have you taken bisphosphonate drugs (Such as; Fosamax, Boniva, Actonel, Zometa)?.....Y N

Do you have joint inflammation, pain, arthritis or rheumatism?.....Y N

Cardiovascular Health:

Are you currently being treated for high blood pressure or cardiovascular disease?.....Y N

Do you currently take blood pressure medicine?.....Y N

Have you had any heart valves replaced?.....Y N

Do you have a history of heart attack, stroke, bypass or stints?.....Y N

Have you ever taken Phen-Phen or Redux?.....Y N

Are you taking blood thinners?.....Y N
If so what kind:

Do you take baby aspirin?.....Y N

Pharmacology:

List all medications you're currently taking, including prescription and OTC meds, vitamins and supplements:

Women Only:

Are you pregnant or could you be pregnant?.....Y N

Are you nursing?.....Y N

Are you taking birth control pills?.....Y N

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

Patient Signature:_____ **Date:**_____

Dr. Signature:_____ **Date:**_____