

IMPRESSIONS DENTAL

5970 S. COOPER RD. STE #1 CHANDLER, AZ 85249 • (480) 814-8888

Health History Form

Reason for today's visit _____

Former Dentist _____ City/State _____

Date of last dental visit _____ Date of last dental x-rays _____

How often do you floss? _____ How often do you brush? _____

Please check all that apply:

- | | | |
|---|--|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Mouth pain, brushing |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Foreign objects | <input type="checkbox"/> Orthodontic treatment |
| <input type="checkbox"/> Blisters on lips or mouth | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Pain around ear |
| <input type="checkbox"/> Burning sensation on tongue | <input type="checkbox"/> Gums swollen or tender | <input type="checkbox"/> Periodontal treatment |
| <input type="checkbox"/> Chew on one side of mouth | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Sensitivity to cold |
| <input type="checkbox"/> Cigarette/pipe/cigar smoking | <input type="checkbox"/> Jaw tiredness | <input type="checkbox"/> Sensitivity to heat |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Lip or cheek biting | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Loose teeth/broken fillings | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Fingernail biting | <input type="checkbox"/> Mouth breathing | <input type="checkbox"/> Sores/growths in mouth |

Health History

Physician's Name _____ Date of Last Visit _____

Have you ever taken any medications containing bisphosphonates? This includes brands such as Fosamax, Actonel, Didronel, Boniva, Aredia, and Zometa. Yes No

Please check all that apply:

- | | | |
|---|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Fainting | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Headaches | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Bleeding abnormally, with extractions or surgery | <input type="checkbox"/> Hepatitis Type _____ | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Herpes | <input type="checkbox"/> Special Diet |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Swollen Feet/Ankles |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Swollen Neck Glands |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cough, persistent/bloody | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tumor or growth on head or neck |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |
| | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Weight Loss/Gain |

Do you wear contact lenses? Yes No Are you taking birth control pills? Yes No

Are you pregnant? Yes No Due Date _____ Are you nursing? Yes No

Medications

List any medications you are currently taking and the correlating diagnosis: _____

Allergies

- | | | |
|---|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Latex | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Metals | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Penicillin | |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Sulfa | |

I authorize and give consent to perform dental services agreed between Impressions Dental and its associates and patient and/or parent or guardian to be necessary or advisable including the use of anesthesia and other medication as indicated. I certify to the accuracy of the above statements regarding my medical and dental history. Payment for all treatment and services rendered are my responsibility.

Signature of patient, parent, guardian or personal representative _____

Printed name of patient, parent, guardian, or personal representative _____

Date _____