Hover Dental Group

Dental Health History

Patient Name_____Birthdate_____Today's Date_____

Dental History

Yes No

- ☐ ☐ Do you have a specific dental problem?
- ☐ ☐ Do you have dental examinations on a yearly basis? Last visit_____
  What was done at your last dental visit?_____
- ☐ ☐ Do you think you have active decay or gum disease?
- ☐ ☐ Do you brush and floss on a daily basis?
- ☐ ☐ Do your gums ever bleed?
- ☐ ☐ Have you ever been told that you have a gum problem?
- ☐ ☐ Does food catch between your teeth?
- ☐ ☐ Do you feel you will eventually lose all your teeth?
- ☐ ☐ Do you ever have clicking, popping or discomfort in the jaw joint?
- ☐ ☐ Do you grind your teeth?
- ☐ ☐ Are you nervous about receiving any dental treatment?
- ☐ ☐ Do you smoke or chew tobacco?
- ☐ ☐ Any sores or growths in your mouth now?
- ☐ ☐ Have there been any complications during previous dental treatment?

OFFICE USE ONLY:
Medical Alert:

Pre-med:

Allergies:

Medical History

Do you now have or have you ever had any of the following? Please check appropriate boxes. If you answer yes to any of the * conditions, premedication with antibiotics may be required before your appointments.

Yes	No		Yes	No		Yes	No	
☐	☐	Heart trouble/disease	☐	☐	Stroke	☐	☐	Artificial joint*
☐	☐	Heart murmur*	☐	☐	Epilepsy or seizure	☐	☐	Venereal disease
☐	☐	Mitral valve prolapse*	☐	☐	Emphysema	☐	☐	Herpes
☐	☐	Rheumatic fever*	☐	☐	Tuberculosis	☐	☐	Tumors or growths
☐	☐	Artificial heart valve*	☐	☐	Cancer	☐	☐	Fainting or dizziness
☐	☐	Heart pacemaker*	☐	☐	Radiation treatment	☐	☐	Drug addiction/alcoholism
☐	☐	Heart surgery	☐	☐	Chemotherapy	☐	☐	Cold sores
☐	☐	High blood pressure	☐	☐	Diabetes	☐	☐	Fever blisters
☐	☐	Anemia	☐	☐	Hypoglycemia	☐	☐	Autism
☐	☐	Bleeding problem	☐	☐	Hepatitis A	☐	☐	Developmentally disabled
☐	☐	Leukemia	☐	☐	Hepatitis B or C	☐	☐	Psychiatric care
☐	☐	Sinus trouble	☐	☐	AIDS	☐	☐	Nervousness
☐	☐	Asthma	☐	☐	HIV positive			

List medications you are taking:

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- ☐ ☐ Are you under a physician's care now? If so,why?_____
- ☐ ☐ Have you ever taken Phen-fen?
- ☐ ☐ Have you ever taken Ephedra?
- ☐ ☐ Are you allergic to any medications or substances? Please check boxes below:
  ☐ aspirin ☐ penicillin ☐ codeine ☐ acrylic ☐ metal ☐ latex rubber

Women: ☐ pregnant/trying to get pregnant ☐ nursing ☐ using birth control

Have you ever had any other serious illness not checked above?_____

X_____Date_____
Patient signature

Reviewed by provider_____Date _____

History Review and significant findings_____

Medical update annually

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

Date	Changes	Patient's Initials	BP	Reviewed By
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____