SOUTH MOUNTAIN FAMILY DENTAL

2233 W. Baseline Rd Suite #104 Tempe, AZ 8583 (602) 438-9245

Health History Form

Reason for today's visit_____

Former Dentist_____City/State_____

Date of last dental visit_____ Date of last dental x-ray_____

How often do you floss? _____How often do you brush? _____ Do you require a pre-medication? _____

Please check all that apply:

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Blisters/sores/growths on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Cigarette/pipe/cigar smoking
- ☐ Clicking or popping jaw
- ☐ Dry mouth
- ☐ Foreign objects
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Gums swollen or tender
- ☐ Jaw pain
- ☐ Jaw tiredness
- ☐ Lip or cheek biting
- ☐ Loose teeth/broken fillings
- ☐ Fingernail biting
- ☐ Mouth pain, brushing
- ☐ Orthodontic treatmen
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Mouth breather
- ☐ Have you ever been diagnosed with Sleep Apnea?
- ☐ Have you ever had an overnight sleep study?
- ☐ Do you or have you used a CPAP?
- ☐ Do you wake up in the morning with headaches?
- ☐ Have you been told that you gasp for air or suddenly stop breathing while sleeping?
- ☐ Do you snore?

Health History

Physician's Name _____ Date of Last Visit_____ Other Medical Conditions not listed below_____

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

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

Medication

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

_____

_____

Allergies

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Other_____

_____

_____

I authorize and give consent to perform dental services agreed between South Mountain Family 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