706 North Azusa Avenue, Azusa, CA 91702
Telephone Number (626) 334 7310
Fax Number (626) 334 7311

Health History Form

Name:____ Date of Birth_________________________

Medication: List all medication you are taking (including over the counter medications)

1)__________________________ 2)__________________________ 3)______________________________

4)__________________________5)__________________________ 6)______________________________

Physician's Name:_______________________________________ Telephone:________________________

Dental History: Have you had any of the following symptoms?

N	Y	Bad Breath
N	Y	Bleeding gums
N	Y	Blisters on lips or mouth
N	Y	Burning Sensation on tongue
N	Y	Chew on one side
N	Y	Use of Tobacco
N	Y	Dry Mouth
N	Y	Fingernail Biting
N	Y	Grinding Teeth

N	Y	Swollen or bleeding gums
N	Y	Jaw pain/Clinching
N	Y	Lip or cheek biting
N	Y	Loose teeth or broken fillings
N	Y	Mouth breathing
N	Y	Mouth pain on brushing
N	Y	Orthodontic Treatment
N	Y	Pain around the ear
N	Y	Gum Disease

N	Y	Sensitivity to cold
N	Y	Sensitivity to hot
N	Y	Sensitivity to sweets
N	Y	Sensitivity or pain on biting
N	Y	Sores or growths in mouth
N	Y	Have you ever had an unpleasant experience to previous dental treatment?

Please explain, if you answered, yes to last question: ____

Previous Dentist's Name: ____

How did you hear about us? ____

What brings you to the Dentist? ____

Health History: (Medical Alerts) Have you had any of the following symptoms or diseases?

N	Y	Anemia
N	Y	Arthritis, Rheumatism
N	Y	Artificial Joints/Pins, Plates
N	Y	Asthma
N	Y	Bleeding abnormality w/surgeries
N	Y	Blood Disease/Hemophilia
N	Y	Cancer/Tumor
N	Y	Chemical /Drug Dependency
N	Y	Cough, Persistent or Bloody
N	Y	Diabetes
N	Y	Epilepsy/Convulsions
N	Y	Heachaches
N	Y	Heart Problems/Murmur
N	Y	High or Low Blood Pressure
N	Y	HIV Positive
N	Y	Kidney Disease
N	Y	Liver Disease/Hepatitis
N	Y	Nervous or Psychiatric Problems
N	Y	Respiratory Disease/Emphysema
N	Y	Rheumatic Fever

N	Y	Use of a Pacemaker
N	Y	Contagious Diseases
N	Y	Premedication
N	Y	Shortness of Breath
N	Y	Sinus Problem
N	Y	Steroid Treatment
N	Y	Stroke
N	Y	Thyroid Problems
N	Y	Tuberculosis
N	Y	Unexplained weight loss
N	Y	Women: Are you pregnant?
N	Y	Mitral Valve Prolapse
N	Y	Back Problems
N	Y	Have you taken Phen-Fen before?
N	Y	Hospitalized in the last 3yrs? Explain
N	Y	Other Medical Problems? Explain
		Are you allergic to Aspirin ____ Sulfa_____, Latex ____, Penicillin ___,Codeine___,Other____

Patient/Parent's Signature____

Dentist's Signature ____ Date ___________________