HEALTH HISTORY

To ensure your well-being while undergoing treatment in our office, please answer the following questions in detail. All information will be considered confidential. Thank you, *David A. Sabourin, D.D.S., APC*

Date of birth: ___________________________________ Today's Date: ______________________________________
Name: ____

To the best of my knowledge all the answers on this Health History form are true and correct. If I have any change in my health or medications, I will inform the doctor at my next appointment. I further authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation. Authorization is also given for dental treatment to be rendered by the dentist and office staff; and I will assume financial responsibility.

Signature: ____
Physician's Name: ____ Physician's Phone: _________________________
Most recent visit to physician: _________________________________ Reason: _________________________________

(*Please circle one*)

Do we have your permission to consult with your physician? YES NO
Are you currently seeing a physician for treatment of a recent or ongoing medical condition? YES NO
If yes, for what condition: ____
When was your last complete physical including blood tests? __________________________________

Have you been hospitalized or had a serious illness within the last year? YES NO
If yes, please explain: ____
Have you ever been advised to take antibiotics before a dental appointment? YES NO
If yes, please explain: ____
Have you had any serious medical trouble associated with any dental experience? YES NO
If yes, please explain: ____

***PLEASE CIRCLE ANY PAST OR CURRENT CONDITIONS*:**

Condition			Condition		
Jaw Joint Pain	YES	NO	Impaired Eyesight/Glaucoma	YES	NO
Arthritis	YES	NO	Hearing Aid/Hearing Disorder	YES	NO
Venereal disease	YES	NO	Kidney Condition: Shunt/Dialysis	YES	NO
Epilepsy/seizures	YES	NO	Frequent Mouth Sores or Lesions	YES	NO
Ulcers	YES	NO	Positive HIV; AIDS; AIDS related complex	YES	NO
Osteoporosis/osteopenia	YES	NO	Autoimmune disorder	YES	NO
Organ transplant	YES	NO	Parkinson's Disease	YES	NO
Depression/Anxiety	YES	NO	Drug/Alcohol addiction	YES	NO
Severe Headaches/Migraines	YES	NO	Steroid (prednisone cortisone) Therapy	YES	NO

Artificial Joint(s) YES NO
If yes, which joints(s): ___________________________ Date of Replacement(s): __________________________
Liver Condition YES NO
If yes, circle condition(s): Jaundice; Cirrhosis; Hepatitis Type A, Type B, Type C, Non-specific
Cancer YES NO
If yes, type: ____
Treatment (circle all that apply) Surgical; Chemotherapy; Radiation

Endocrine:

Thyroid Disease YES NO
Diabetes: YES NO
If yes, complete the following:
(*circle*) Type I; Type II
Do you require insulin? YES NO
Your last Hemoglobin A1c: ____________________________
How often do you have HbA1c tested? 3mo 6mo 12mo
How often do you check your blood sugar? ______________

Circulation:

Arterio/atherosclerosis	YES	NO	Heart Surgery: (*circle*) Bipass, Valve, Other	YES	NO
High Cholesterol	YES	NO	Rheumatic Fever; Rheumatic Heart Disease	YES	NO
High/Low Blood Pressure	YES	NO	Pacemaker: If yes, date placed: ____________	YES	NO
Mitral Valve Prolapse	YES	NO	Heart Attack(s): If yes, date: _______________	YES	NO
Heart Murmur	YES	NO	Stroke	YES	NO
Angina (chest pain)	YES	NO	Blood/Bleeding disorder	YES	NO
Congestive Heart Failure	YES	NO	Congenital Heart Defect	YES	NO

Respiratory:

Chronic Lung Disease	YES	NO	Tuberculosis	YES	NO
Asthma	YES	NO	Ever Exposed to TB	YES	NO
Hay Fever/Allergies	YES	NO	Persistent Cough or Cough up Blood	YES	NO
Emphysema	YES	NO	Chronic Sinus	YES	NO
Current Use of Tobacco	YES	NO			

If yes, type: (*circle*) Cigarettes; Snuff/Chew; Cigar; Pipe

If yes, How much per day? ________________________ Years of Use? ______________________________

Past history of Tobacco Use Yes NO If yes, when quit? _________________________________

Allergies:

If allergic or have had previous reactions to the following (*Circle any/all that apply*)

Aspirin; Penicillin; Tetracycline; Erythromycin; Sulfa; Latex; Codeine; Barbiturates; Tranquilizers; Dental anesthetic; Other: _______________________________________

Have you ever had an adverse reaction (nausea, dizziness, hives, rash, difficulty breathing, etc.) with any medicine? YES NO If yes, please explain: ______________________________

____

Do you have any medical problem/condition not listed that you feel we should know about? YES NO

If yes, explain: ____

WOMEN ONLY:

Are you currently pregnant? *YES* *NO* *If yes, expected delivery date:* ______________________

Are you nursing? *YES* *NO* *Are you going or gone through menopause?* *YES* *NO*

Are you currently receiving *intravenous* Bisphosphonates? YES NO

If yes, for how long: ____________________________

Are you currently taking *oral* Bisphosphonates (Fosamax, Actonel, Boniva)? YES NO

If yes for how long: _____________________________

Have you been treated with this type of medication in the past? YES NO

Herbal Medications/Supplements/Prescriptions:

Are you taking any of the following herbal medications/supplements? (*Circle any/all that apply*)

Echinacea	Licorice	Ginseng	Ephedra/Ma huang	Garlic/ajo	St. John's Wort	
Ginko	Valerian	Ginger	Feverfew	Coenzyme/Q10	Goldenseal	Saw Palmetto

Please list all: Prescriptions medications, herbal medications (other than indicated above) and vitamins or supplements that you are currently taking:

Name of medication: Dosage: Condition/Reason you are taking:

____

____

____

____

DENTAL HISTORY:

Previous Dentist: ______________________________ How long had you been a patient? __________________
Date of most recent dental exam: __________________ Date of most recent x-rays ________________________
Date of most recent treatment (other than a professional cleaning): _____________________________________
I routinely see my dentist every: _____3 mos _____4 mos _____6 mos _____12 mos _____not routinely
What is your immediate concern? ____
PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY

1. Are you fearful of dental treatment? If yes, rank on a scale of 1 (least) to 10 (most): _______ YES NO
2. Have you had an unfavorable dental experience? YES NO
3. Have you ever had complications from past dental treatment? YES NO
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? YES NO
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? YES NO
6. Have you had any teeth removed or missing teeth that never developed? YES NO

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? YES NO
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? YES NO
9. Have you ever noticed an unpleasant taste or odor in your mouth? YES NO
10. Is there anyone with a history of periodontal disease in your family? YES NO
11. Have you ever experienced gum recession? YES NO
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? YES NO
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? YES NO

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? YES NO
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? YES NO
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? YES NO
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? YES NO
18. Do you have grooves or notches on your teeth near the gum line? YES NO
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? YES NO
20. Do you frequently get food caught between any teeth? YES NO

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) YES NO
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? YES NO
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? YES NO
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? YES NO
25. Are your teeth becoming more crooked, crowded, or overlapped? YES NO
26. Are your teeth developing spaces or becoming looser? YES NO
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? YES NO
28. Do you place your tongue between your teeth or close your teeth against your tongue? YES NO
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? YES NO
30. Do you clench your teeth in the daytime or make them sore? YES NO
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? YES NO
32. Do you wear or have you ever worn a bite appliance? YES NO

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change? YES NO
34. Have you ever whitened (bleached) your teeth professionally? YES NO
35. Have you felt uncomfortable or self-conscious about the appearance of your teeth? YES NO
36. Have you been disappointed with the appearance of previous dental work? YES NO