**TEAGUE DENTISTRY - HEALTH HISTORY FORM  
 *To serve you properly, we request the following information. All information will be strictly confidential.*

**PERSONAL INFORMATION**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

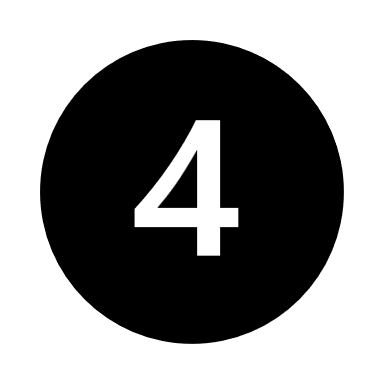
**  
DENTAL INFORMATION** (*please mark* X *your responses to the following questions*)

Are your teeth sensitive to cold, hot, sweets, or pressure?...........................................................................  Y  N  
Have you had any periodontal (gum) treatments?........................................................................................  Y  N  
Are you currently experiencing dental pain or discomfort?..........................................................................  Y  N  
Do you have any clicking, popping, or discomfort in the jaw?......................................................................  Y  N  
Do you brux or grind your teeth?..................................................................................................................  Y  N  
Do you have sores or ulcers in your mouth?.................................................................................................  Y  N  
Do you wear dentures or partials?................................................................................................................  Y  N  
Have you ever had a serious injury to your head or mouth?........................................................................  Y  N  
What is the reason for your visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

****  
**MEDICAL INFORMATION** (*please mark* X *your responses to the following questions*)

Cardiovascular disease…………………………  Y  N  
Pacemaker…………………………………………..  Y  N  
Arthritis……………………………………………….  Y  N  
Autoimmune disease…………………………..  Y  N  
Asthma………………………………………………..  Y  N  
Epilepsy……………………………………………….  Y  N  
Tuberculosis………………………………………..  Y  N  
Knee/Hip/Joint replacement..................  Y  N

Valve replacement .................................  Y  N  
Eating disorder…………………………………….  Y  N  
Gastrointestinal disease……………………….  Y  N  
Thyroid problems…………………………………  Y  N  
Stroke………………………………………………….  Y  N  
Kidney problems………………………………….  Y  N  
Osteoporosis……………………………………....  Y  N  
Severe headaches/migraines……………….  Y  N

Are you taking or will you begin taking an antiresorptive agent for osteoporosis or Paget’s disease?..........  Y  N  
Do you use controlled substances (drugs)?...................................................................................................  Y  N  
Do you use tobacco (smoking, snuff, chew, bidis)?........................................................................................  Y  N  
If yes, are you interested in stopping?...........................................................................................................  Y  N  
**Women,** are you pregnant?...........................................................................................................................  Y  N  
Please list any medications you are taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*CONTINUE ON BACK IF NEEDED*

**ALLERGIES** (*please mark* X *your responses to the following questions*)

Local anesthetics...................................  Y  N  
Aspirin...................................................  Y  N  
Penicillin................................................  Y  N  
Erythromycin.........................................  Y  N  
Tetracycline...........................................  Y  N  
Sulfa......................................................  Y  N  
Codeine.................................................  Y  N  
Latex......................................................  Y  N  
Metals...................................................  Y  N  
Iodine....................................................  Y  N  
Barbiturates or sedatives......................  Y  N  
Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Note:** **Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.***I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.*

**SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

*PATIENT OR RESPONSIBLE PARTY SIGNATURE*