SALNICK DENTAL
FAMILY & COSMETIC DENTISTRY
We're Here To Keep You Smiling!

Medical/Dental Health History

Date______________

Confidential
Please complete in full all that applies.

Name:____ Birthdate:___/___/____ Age:______

What is the reason for today's visit?: ____

Physicians Name:____________________________ Date of last exam___/___/____

1. Are you currently taking a pre-med? Yes / No If yes, why:____
2. Do you take any blood thinners(aspirin, cumaden, etc.) Yes / No If yes, what:_________________________
3. (Women) Are you pregnant? Yes / No If yes, Trimester:_____ Due Date:___/___/____
4. Do you use tobacco in any form? Yes/ No If yes, what type:________ How Much:_____________
5. Do you have allergies to anesthetics or medicines? Which ones:____________________________________

Do you have or have you had any of the following (check all that apply):

❑Heart Problems	❑High/Low Blood pressure	❑Circulatory problems	❑Nervous System problems
❑HIV/AIDS	❑Anemia	❑Arthritis	❑Chemo Therapy
❑Diabetes	❑Hepatitis	❑Herpes	❑Migraines
❑Asthma	❑Psychiatric Care	❑Rheumatic Fever	❑Hepatitis
❑Sinus Problems	❑Stroke	❑Radiation Therapy	❑Epilepsy
❑Tuberculosis	❑Ulcer	❑Artificial Joints	❑Other, List Below

Please describe any other medical problems, operations, impending operations, or activities that may possibly affect your dental treatment. **Please also list medications.**

____

____

When was your last dental visit?___-___-____ Did you have x-rays at that time? Yes / No

Do you have regular dental check-ups? Yes / No If yes, what interval? ❑1Year ❑6month ❑4month ❑3month

Have you ever had any serious problems with previous dental treatment? Yes / No

If yes, what?____

Does dental treatment make you nervous? ❑No ❑Slightly ❑Moderately ❑Extremely

Have you ever been treated for periodontal disease(gum disease)? Yes / No

Have you had any teeth removed? Yes / No If yes, did you have any bleeding or clotting problems? Yes / No

Do you or have you had any of the following:

❑Toothaches	❑Bleeding Gums	❑Clenching/Grinding	❑Sensitivity to hot/cold
❑Canker Sores	❑Cold Sores	❑Loose teeth	❑Clicking, popping, jaw pain
❑Migraines	❑Braces	❑Chipped/Broken Teeth	❑Root canal therapy

I certify that I have read and answered or checked, to the best of my knowledge, all of the above statements that apply. All questions about the above statements have been answered. I will not hold the dentist, or any staff members responsible for any mistakes that I may have made.

____ ______________________

Signature of patient or parent/guardian Date