Paul Lonstein, DMD, PC

(PLEASE PRINT IN INK)

HEALTH HISTORY

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Check yes or no, whichever applies, in response to the following questions. Your answers are for our records only and will be considered confidential.

Name _____ Birth date _____ Age _____

Why are you seeking dental treatment? _____

Please answer each question. Circle Yes or No, if in doubt, leave blank.

1. Are you in good health now?..... Y N
2. Are you now under the care of a physician?..... Y N
   If so, what is the condition being treated?_____
3. Have you ever been hospitalized or had a serious illness?..... Y N
   If yes, explain_____
4. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal than previously? Y N
5. (Women) Are you pregnant? If so, give due date_____
6. Do you use tobacco in any form? If yes, how much?..... Y N
7. Do you use alcoholic beverages (more than 2 drinks per day)?..... Y N
8. Do you now or have you ever used recreational drugs? ..... Y N
9. Do you have or have you ever had any of the following (Please Circle Y or N)

GENERAL

Tire easily, weakness..... Y N
Marked weight change ..... Y N
Night Sweats..... Y N
Persistent fever..... Y N

SKIN

Eruptions (rash) hives..... Y N
Change in skin color ..... Y N

EYES

Visual Change..... Y N
Glaucoma..... Y N

EARS

Loss of hearing..... Y N
Ringing in ears..... Y N

NOSE

Frequent nosebleeds..... Y N
Sinus problems..... Y N

THROAT

Soreness / hoarseness..... Y N

NERVOUS SYSTEM

Stroke..... Y N
Headaches..... Y N
Convulsion / epilepsy..... Y N
Numbness /tingling..... Y N
Dizziness / fainting..... Y N
Psychiatric treatment..... Y N
ADD / ADHD ..... Y N

RESPIRATORY

Tuberculosis..... Y N
Emphysema..... Y N
Asthma / hay fever..... Y N
Persistent cough..... Y N
Sputum production (phlegm)..... Y N
Cough up bloody sputum..... Y N
Difficulty breathing while lying down..... Y N

ENDOCRINE

Diabetes..... Y N
Family history of diabetes..... Y N
Thyroid condition /goiter..... Y N
Other..... Y N
Have you ever taken prescription weight loss medicines (ex. Fen/Phen, Redux)?..... Y N

HEART / BLOOD VESSELS

Rheumatic fever..... Y N
Murmur, damaged or leaking heart Valves..... Y N
Chest pain / discomfort..... Y N
Heart attack / trouble..... Y N
Shortness of breath..... Y N
Swelling of ankles..... Y N
High blood pressure..... Y N
Congenital heart disease..... Y N
Mitral valve prolapse..... Y N
Artificial heart valve..... Y N
Cardiac Pacemaker..... Y N
Heart surgery or inborn heart defect..... Y N
Other _____

BONE / MUSCLES

Arthritis / rheumatism..... Y N
Artificial joints /limbs..... Y N

DIGESTIVE SYSTEM

Hepatitis..... Y N
Jaundice..... Y N
Ulcers..... Y N
Change in appetite..... Y N
Black, bloody, or pale stools..... Y N

URINARY

Kidney disease ..... Y N
Increase in frequency of urination (night)..... Y N
Burning on urination..... Y N
Urethral discharge..... Y N
Bloody urine..... Y N
Venereal disease..... Y N

BLOOD

Bruise easily..... Y N
Anemia ..... Y N
Blood transfusion..... Y N

OTHER

Radiation therapy..... Y N
Chemotherapy..... Y N
Tumors or growths..... Y N
Cancer..... Y N
HIV+..... Y N
AIDS..... Y N

(Please complete reverse side)

9. Are you ALLERGIC or have you ever experienced any reaction to the following? (Circle Yes or No)

Local anesthetics (e.g. Novocain)……..	Y	N	Sulfa drugs …….	Y	N
Barbiturates / sedatives / sleeping pills ……..	Y	N	Latex Allergy ……	Y	N
Penicillin / other antibiotics ……..	Y	N			
Aspirin or Codeine …….	Y	N	Other Allergies _____		

10. Are you taking any of the following? (Circle Yes or No)

Antibiotics / sulfa drugs……..….	Y	N	Tranquilizers……..	Y	N
Blood thinners……..	Y	N	Insulin / other diabetes drugs……	Y	N
Blood pressure medications……..	Y	N	Digitalis / other heart medications……	Y	N
Thyroid medicines……..	Y	N	Nitroglycerin……..	Y	N
Cortisone / steroids……	Y	N	Aspirin……..	Y	N
Antihistamines / allergy drugs/ cold remedies…	Y	N	Other medications _____		

If yes to any of the above, list ***name*** of medication and ***dosage*** below:

_____ _____

_____ _____

_____ _____

11. Is there any disease, condition, or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? I so, explain _____

_____

12. Physician's Name _____ Phone _____

13. Have you ever had any serious trouble associated with previous dental treatment?
_____

14. Does dental treatment make you nervous? (please circle) No Slightly Moderately Extremely

15. Date of last dental visit _____

16. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____

If so when? _____

17. Do you have or have you ever had any of the following?

MOUTH

Bleeding, sore gums……	Y	N
Unpleasant taste/bad breath……	Y	N
Burning tongue / lips……..	Y	N
Frequent blisters, lips / mouth……..	Y	N
Swelling / lumps in mouth……..	Y	N
Ortho treatments (braces)…….	Y	N
Biting cheeks / lips……..	Y	N
Clicking / popping jaw…….	Y	N
Difficulty open or closing jaw…….	Y	N

TEETH

Loose teeth……	Y	N
Sensitive to hot……..	Y	N
Sensitive to cold……	Y	N
Sensitive to sweets……..	Y	N
Sensitive to biting……..	Y	N
Food impaction……..	Y	N
Clenching / grinding……..	Y	N
Shifting of teeth……..	Y	N
Change in bite……	Y	N

ORAL HYGIENE

Do you use the following (Circle):
Brush Dental floss Fluoride rinse

Other _____
How often do you brush_____
Brush is (please circle) Soft Medium Hard

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment. I also indicate that I have read the contents of this document and am fully familiar with its content. I understand that all services rendered to the undersigned by this office shall be a personal responsibility of mine for which I am obligated to pay this office independent of any insurance coverages or agreements which may be applicable hereto.

Signature of Patient,
Parent, or Guardian _____ Date _____

Office use only: Health information reviewed [ ] Doctors Initials: