Synergy
PERIODONTICS & IMPLANTS
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Health History

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PATIENT NAME (Last, First)	PATIENT ACCOUNT NO. (OFFICE ONLY)
DATE OF BIRTH (MM/DD/YYYY)	MEDICAL ALERT (OFFICE ONLY)

Welcome! *So that we may provide you with the best possible care, please complete this Health History form. All information is completely confidential.*

What is the reason for your visit today?

____

Date of Last Dental Visit ____________ **Last Dental Cleaning** ____________ **Last Full Mouth X-rays** ____________

____
WHAT WAS DONE AT YOUR LAST DENTAL VISIT?

______________________________ ______________________________
CURRENT DENTIST'S NAME PHONE

______________________________ ____________ ______ __________
ADDRESS CITY STATE ZIP CODE

How often do you have dental examinations? ______________________________

How often do you brush your teeth? ____________ How often do you floss? ____________

What other dental aids do you use? (Interplak, toothpick, etc.) ______________________________

Do you have any dental problems now? ◯ Yes ◯ No

____
IF YES, PLEASE DESCRIBE

Are any of your teeth sensitive to:	**Y**	**N**
Hot or cold?	◯	◯
Sweets?	◯	◯
Biting or Chewing?	◯	◯
Have you noticed any mouth odors or bad tastes?	◯	◯
Do you frequently get cold sores, blisters, or any other oral lesions?	◯	◯
Do your gums bleed or hurt?	◯	◯
Have your parents experienced gum disease or tooth loss?	◯	◯
Have you noticed any loose teeth or change in your bite?	◯	◯

Do you:	**Y**	**N**
Clench or grind your teeth while awake or asleep?	◯	◯
Bite your lips or cheeks regularly?	◯	◯
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	◯	◯
Mouth breathe while awake or asleep?	◯	◯
Have tired jaws, especially in the morning?	◯	◯
Smoke/chew tobacco?	◯	◯

Have you ever had:	**Y**	**N**
Orthodontic treatment?	◯	◯
Oral surgery?	◯	◯
Periodontal treatment?	◯	◯
Your teeth ground or the bite adjusted?	◯	◯
A bite plate or mouth guard?	◯	◯
A serious injury to the mouth or head?	◯	◯

If so, please describe, including cause:

____

Have you experienced:	**Y**	**N**
Clicking or popping of the jaw?	◯	◯
Pain? (joint, ear, side of face)	◯	◯
Difficulty in opening or closing the mouth?	◯	◯
Difficulty in chewing on either side of the mouth?	◯	◯
Headaches, neckaches or shoulder aches?	◯	◯
Sore muscles (neck or shoulders)?	◯	◯
Are you satisfied with your teeth's appearance?	◯	◯
Would you like to keep all of your teeth all of your life?	◯	◯
Do you feel nervous about having dental treatment?	◯	◯

If so, what is your biggest concern?

____

Have you ever had an upsetting dental experience? ○ Yes ○ No

IF YES, PLEASE DESCRIBE

Is there anything else about having dental treatment that you would like us to know? ○ Yes ○ No

IF YES, PLEASE DESCRIBE

Do you have a primary care physician? ○ Yes ○ No If yes, please give contact information below.

PHYSICIANS NAME | PHONE

ADDRESS | CITY | STATE | ZIP CODE

Are you taking any medication, drugs or pills now? ○ Yes ○ No If Yes, please list name and dosage.

MED 1	DOSE	MED 2	DOSE	MED 3	DOSE	MED 4	DOSE
MED5	DOSE	MED 6	DOSE	MED 7	DOSE	MED 8	DOSE
MED 9	DOSE	MED 10	DOSE	MED 11	DOSE	MED 12	DOSE

Are you aware of having an allergic reaction (or adverse reaction) to any medication or substance? ○ Yes ○ No

IF YES, PLEASE LIST

Have you been a patient in the hospital during the past five years? ○ Yes ○ No

Indicate which of the following you have had, or have at present. Check **Y** (Yes) or **N** (No) for each item.

	Y	N		Y	N		Y	N
Heart (Surgery, Disease, Attack)	○	○	Diabetes	○	○	Venereal Disease	○	○
Chest Pain	○	○	Thyroid Problems	○	○	A.I.D.S.	○	○
Congenital Heart Disease	○	○	Glaucoma	○	○	H.I.V. Positive	○	○
Heart Murmur	○	○	Contact Lenses	○	○	Cold Sores/Fever Blisters	○	○
High Blood Pressure	○	○	Emphysema	○	○	Blood Transfusion	○	○
Mitral Valve Prolapse	○	○	Chronic Cough	○	○	Hemophilia	○	○
Artificial Heart Valve	○	○	Tuberculosis	○	○	Sickle Cell Disease	○	○
Heart Pacemaker	○	○	Asthma	○	○	Bruise Easily	○	○
Rheumatic Fever	○	○	Hay Fever	○	○	Liver Disease	○	○
Arthritis/Rheumatism	○	○	Latex Sensitivity	○	○	Yellow Jaundice	○	○
Cortisone Medicine	○	○	Allergies or Hives	○	○	Neurological Disorders	○	○
Swollen Ankles	○	○	Sinus Trouble	○	○	Epilepsy or Seizures	○	○
Stroke	○	○	Radiation Therapy	○	○	Fainting or Dizzy Spells	○	○
Diet (Special Restricted)	○	○	Chemotherapy	○	○	Nervous/Anxious	○	○
Artificial Joints (hip, knee, etc.)	○	○	Tumors	○	○	Psychiatric Care	○	○
Kidney Trouble	○	○	Hepatitis A (infectious)	○	○	Psychological Care	○	○
Ulcers	○	○	Hepatitis B	○	○	Sleep Apnea	○	○
			Hepatitis C	○	○	Daytime Sleepiness	○	○

Have you ever taken Fosamax, Zometa, Aredia, Actonel, or any other oral or intravenous medication (biphosphates) for bone tumors, excess calcium or osteoporosis? ○ Yes ○ No

Do you have or have you had any disease, condition, or problem not listed above? ○ Yes ○ No

IF YES, PLEASE LIST

Have you ever used tobacco products? ○ Yes ○ No If yes, how much per day? ______ How many years? ______

Do you want to quit? ○ Yes ○ No

Number of alcoholic drinks per week? ______

History of or current substance abuse? ○ Yes ○ No

Women - Are you: **Pregnant?** ○ Yes ○ No No. of months _______ **Nursing?** ○ Yes ○ No

Taking birth control pills? ○ Yes ○ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

X ____

PATIENT/GUARDIAN SIGNATURE DATE

X ____

DOCTOR SIGNATURE DATE