## THOMAS G FAIVER, DDS, PC
# HEALTH HISTORY

Name_____ Birth date_____ Today's date_____

Physician_____ Date of last physical_____

Previous dentist and location_____

Date of last dental visit_____ Last x-rays_____ How many_____

Today's main concern _____

Have you ever responded adversely to medical or dental treatment?_____

Have you ever had any unfavorable dental experience?_____

Is there anything else we should know about your dental or medical history?_____

_____

**DENTAL HISTORY:** (please check circles that apply)

| | | |
|---|---|---|
| O Bad breath | O Any piercing | O Mouth pain, brushing |
| O Bleeding gums | O Fingernail biting | O Orthodontic treatment |
| O Blisters on lips/mouth | O Food collection between teeth | O Periodontal treatment |
| O Burning sensation on tongue | O Grinding/clenching teeth | O Sensitivity to cold |
| O Chew on one side of mouth | O Gums swollen or tender | O Sensitivity to hot |
| O Cigarette/pipe/cigar smoking | O Lip/cheek biting | O Sensitivity to sweets |
| O Smokeless tobacco | O Loose teeth | O Sensitivity to biting |
| O Clicking or popping jaw | O Broken fillings | O Sores or growths in mouth |
| O Dry mouth | O Mouth breathing | |

How often do you brush? _____ How often do you floss? _____

**MEDICAL HISTORY:** (please check circles that apply)

| | | |
|---|---|---|
| O Heart problems | O Respiratory disease | O Arthritis |
| O High blood pressure | O headaches | O Rheumatic fever |
| O Low blood pressure | O Hepatitis/jaundice | O Sinus problems |
| O Circulatory problems | O Liver disease | O HIV/AIDS/Immune disorders |
| O Radiation treatment | O Cancer/chemotherapy | O Venereal disease |
| O Artificial heart valve(s) or joints | O Allergies to anesthetics | O Hemophilia |
| O Back problems | O Allergies to medications/drugs | O Pacemaker |
| O Diabetes | O General allergies | O Kidney disease |
| O Anemia | O Blood disease | O Tuberculosis |
| O Head or neck tumors | O Herpes | |

Are you currently taking any medications?_____ If so, please list_____

Please list all allergies_____

Women: Possibility of pregnancy? **Y N** Are you nursing? **Y N**

Patient Signature_____ Date_____
Parent/Guardian if minor