Center for Oral and Maxillofacial Surgery, Joe L. Carpenter, DMD, Inc.

HEALTH HISTORY

Name _____ **Birthdate** _____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING – INDICATE WITH A (✓)

☐ Moved from a large metropolitan area in the past year
☐ Teeth sensitive to cold, heat, sweets or pressure
☐ Bleeding gums, How long _____
☐ Food impaction
☐ Clenching or grinding
☐ Burning of tongue
☐ Swelling or lumps in mouth
☐ Frequent blisters on lips or mouth
☐ Bad breath
☐ Unpleasant taste
☐ Unfavorable dental experience
☐ Complications from extractions
☐ Periodontal treatment
☐ Orthodontic treatment
☐ Mouth breathing
☐ Cigarettes, pipe, cigar, tobacco How Much____
☐ TMJ of Jaws How Long_____
☐ Pain around ear
☐ Unusual sounds in ear while eating
☐ Oral habits, i.e., fingernail biting, cheek biting
☐ Gag easily
☐ Alcohol Use How Much____ How long_____

PLEASE MARK ALL BOXES YES OR NO – HAVE YOU EVER BEEN TREATED FOR:

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Allergies to drugs – List _____ _____ _____	☐	☐	Anemia or blood problems	☐	☐	Hepatitis	☐	☐	Sleep Apnea
☐	☐	Allergies to anesthetics	☐	☐	Arthritis	☐	☐	Rheumatic fever	☐	☐	Thyroid
☐	☐	Any heart ailments	☐	☐	Artificial Joints	☐	☐	Malignancies or Radiation Treatments	☐	☐	Eye disorders - Glaucoma
☐	☐	High blood pressure	☐	☐	Cortisone Treatment	☐	☐	Fever – chills	☐	☐	Tonsillitis
☐	☐	Heart Murmur	☐	☐	Asthma	☐	☐	Chemotherapy	☐	☐	Tuberculosis
☐	☐	Artificial Heart Valve	☐	☐	Hay fever or allergies in general	☐	☐	Psychiatric care/ emotional problems	☐	☐	Ulcer or colitis
☐	☐	Mitral Valve Prolapse	☐	☐	Latex Sensitivity	☐	☐	Sinus problems	☐	☐	Are You Now Pregnant If so, what month _____
☐	☐	Pacemaker	☐	☐	Diabetes	☐	☐	Neurological problems	☐	☐	Venereal disease
☐	☐	Excessive bleeding from cut or extraction	☐	☐	Diarrhea	☐	☐	Stroke	☐	☐	Herpes
			☐	☐	Kidney Problems	☐	☐	Night Sweats	☐	☐	Phen Phen-Diet Pills-Herbs
			☐	☐	Liver Problems				☐	☐	Bisphosphonate Drugs for Osteoporosis (Fosamax, Boniva, Actonel)

Physician's Name_____ Date of Last Physical Exam _____

Are you currently being treated for any infectious conditions No ☐ Yes ☐ List _____

_____

Describe any current medical treatment including medications taken, even though not listed above:

_____

_____

_____

ATTENTION: FEMALE PATIENTS - If there is the slightest chance you are pregnant, you need to be aware that many aspects of medical dental treatment could be harmful to you and/or the fetus, including, but not limited to: X-RAYS, ALL MEDICATIONS, including ibuprofen, aspirin, etc. **IT IS ESSENTIAL THAT YOU ADVISE OUR OFFICE PRIOR TREATMENT IF THERE IS ANY POSSIBILITY YOU ARE PREGNANT.**

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I understand it is my responsibility to inform this office of any changes in my/patient's medical condition or medical history.

Signature_____ **Date** _____

(Patient – Unless a minor – then Parent or Legal Guardian Signature)