

Date: _____



SUSAN L. SOCKWELL D.M.D.

PATIENT HEALTH HISTORY

Confidential

Patient Name: _____, _____ MI Date of Birth: _____ - _____ - _____
Last First MI Month Date Year

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former dentist _____ Date of last dental x-rays _____

Contact information for previous dentist _____

Check the below if you have had problems with any of the following::

<input type="checkbox"/> Bad Breath	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Sensitivity to hot
<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Loose teeth or broken fillings	<input type="checkbox"/> Sensitivity to sweets
<input type="checkbox"/> Clicking or popping jaw	<input type="checkbox"/> Periodontal treatment	<input type="checkbox"/> Sensitivity when biting
<input type="checkbox"/> Food collections between teeth	<input type="checkbox"/> Sensitivity to cold	<input type="checkbox"/> Sores and growths in your mouth

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

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? _____ If yes, describe _____

Joint replacement? No Yes. If yes, list joint and date? _____ Pre-med needed?

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check the below if you have or have had any of the following:

<input type="checkbox"/> Anemia	<input type="checkbox"/> Cough, Persistent	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Arthritis, Rheumatism	<input type="checkbox"/> Cough up Blood	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Skin Rash
<input type="checkbox"/> Artificial Heart Valves	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Swelling of Feet and Ankles
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Fainting	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Tobacco Habit
<input type="checkbox"/> Cancer	<input type="checkbox"/> Headaches	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Tonsilitis
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Respiratory Disease	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Cortisone Treatments	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/>

(Turn over to complete.)

