AAA Court Family Dental
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Name_____Date:_____

Health History

Has there been any changes in your health within the past year? ◯ Yes ◯ No If yes, explain:_____

Are you currently under medical care? ◯ Yes ◯ No If yes, explain:_____
Have you ever had a serious illness or operation? ◯ Yes ◯ No If yes, explain:_____
Have you ever had an artificial joint replacement? ◯ Yes ◯ No If yes, when?_____
Have you ever had surgery or x-ray treatment for tumor, growth or other condition? ◯ Yes ◯ No If yes, explain:_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No
Are you currently taking anticoagulants (blood thinners) ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use recreational drugs or substances? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Local anesthetics (lidocaine, etc) ☐ Antibiotics (penicillin, sulfa, etc) ☐ Aspirin or anti-inflammatory drugs ☐ Narcotic analgesics ☐ Anti-anxiety drugs ☐ Latex ☐ Metal
☐ Other If yes, please explain:_____

Do you have, or have you had, any of the following?

Rheumatic fever or rheumatic heart disease	◯ Yes	◯ No	Ulcers (stomach or intestinal)	◯ Yes	◯ No	Swollen ankles	◯ Yes	◯ No
Congenital heart disease	◯ Yes	◯ No	Acid reflux (GERD)	◯ Yes	◯ No	Bleeding disorder	◯ Yes	◯ No
Cardiovascular disease (endocarditis, heart attack)	◯ Yes	◯ No	Persistent cough, or coughing up blood	◯ Yes	◯ No	Difficulty breathing when you lie down	◯ Yes	◯ No
Chest pain or shortness of breath	◯ Yes	◯ No	Hepatitis, jaundice, or liver disease	◯ Yes	◯ No	Ulcers (stomach/intestine)	◯ Yes	◯ No
High blood pressure	◯ Yes	◯ No	Kidney trouble (nephritis, etc)	◯ Yes	◯ No	Tumors or growths	◯ Yes	◯ No
Hives/skin rash	◯ Yes	◯ No	Venereal disease	◯ Yes	◯ No	Stroke	◯ Yes	◯ No
Fainting spells	◯ Yes	◯ No	Epilepsy or seizure disorder	◯ Yes	◯ No	Diabetes	◯ Yes	◯ No
Tuberculosis	◯ Yes	◯ No	Immune system depression (HIV/AIDS, organ transplant)	◯ Yes	◯ No	Arthritis (rheumatoid/osteo)	◯ Yes	◯ No
Allergy or hay fever	◯ Yes	◯ No	Substance abuse	◯ Yes	◯ No	Asthma	◯ Yes	◯ No

Do you have any disease, condition, or problem not listed above? _____

Women: are you
Pregnant/trying to become pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Please list all medications you are currently taking:

Name of medication	What is it taken for?

Dental History

Date and location of last dental exam: _____
Any serious trouble associated with previous dental treatment? _____
Do you suffer from dry mouth? ◯ Yes ◯ No If yes, explain:_____
Are you happy with the appearance of your teeth? ◯ Yes ◯ No If no, explain:_____
Do you suffer from dry mouth? ◯ Yes ◯ No If yes, explain:_____
Have you ever been told you have gum disease? ◯ Yes ◯ No If yes, explain:_____
Do your gums bleed when you brush your teeth? ◯ Yes ◯ No If yes, explain:_____
Do you grind or clench your teeth? ◯ Yes ◯ No If yes, explain:_____
Do you often have toothaches? ◯ Yes ◯ No If yes, explain:_____
Do you have frequent sores/swelling in your mouth? ◯ Yes ◯ No If yes, explain:_____
Have you had any injuries to your mouth/jaw? ◯ Yes ◯ No If yes, explain:_____
Have you been satisfied with previous dental care? ◯ Yes ◯ No If yes, explain:_____