

## Health History

We would like to welcome you to our office and thank you for choosing us as your oral health care provider. We the staff of Sabre Springs Dentistry are committed to exceeding the expectation of our clients every day. In order to address your oral health care needs safely and efficiently we need information about your general and oral health. We appreciate your cooperation in providing us with accurate information. If you have any questions we will be glad to help you. (if you do not see the fill out fields (sky blue background) please click on "Highlith Fields" bottom at the top righthand corner of this page).

**Patient Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ **Text** \_\_\_\_\_ **Date** \_\_\_\_\_

Are you currently under the care of a physician? Yes \_\_\_\_\_ No \_\_\_\_\_ If "Yes" What is it for? \_\_\_\_\_

Date of last visit to your Physician: \_\_\_\_\_ Physicians name \_\_\_\_\_ Phone # \_\_\_\_\_

Are you taking any medications including over the counter ones. Yes \_\_\_\_\_ No \_\_\_\_\_ If "Yes" please list the **Name, Dose and Frequency** of medication, (please use separate sheet if needed)

.Have you had any serious illness or operations in the last five years? Yes \_\_\_\_\_ No \_\_\_\_\_ If "Yes", please describe \_\_\_\_\_

Are you aware of having an allergic reaction to any of these medication or substances? If "yes" please check off Aspirin \_\_\_\_\_ Codeine \_\_\_\_\_

Dental Anesthesia \_\_\_\_\_ Latex \_\_\_\_\_ Metals \_\_\_\_\_ Penicillin \_\_\_\_\_ Sulfa \_\_\_\_\_ Erythromycin \_\_\_\_\_ Others \_\_\_\_\_

Please mark on "Yes" if you have had or on "No" if you have not had any of the following medical conditions:

Condition	Yes No		Condition	Yes No		Comments (office use only)
Abnormal bleeding			Heart murmur			
Alcohol abuse			Heart Surgery			
Anemia			Hemophilia			
Angina Pectoris/Chest pain			Hepatitis B			
Arthritis			Hepatitis C			
Artificial Heart valve			High blood pressure			
Asthma			Joint replacement			
Back/ neck pain			Jaundice			
Blood Transfusion			Kidney / bladder disease			
Cancer			Liver disease			
Chemotherapy			Migraine			
Colitis			Mitral Valve proplase			
Congenital Heart Defect			Pacemaker / defibrillator			
Coronary angioplasty			Osteoporosis			
Coronary bypass			Osteoarthritis			
Diabetes			Psychiatric Problems			
Difficulty Breathing			Radiation therapy			
Drug Abuse			Rheumatic Fever			
Emphysema			Sexually transmitted disease			
Epilepsy/ Seizures			Sickle Cell Anemia			
Fainting Spells			Sinus Problems			
Frequent Headache			Stroke			
Glaucoma			Thyroid Problems			
HIV+/AIDS			Tuberculosis			
Heart Attack			Ulcer			

.Do you have or have you had any other conditions not listed above? Yes \_\_\_\_\_ No \_\_\_\_\_ if "Yes: please describe: \_\_\_\_\_

Have you ever taken any of the drugs collectively referred to as: fen-Phen"? These include combinations of Lonimin, Adipex, fastin, Pondimin and Redux ? Yes No

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If "Yes" has you had Bisphosphonate IV therapy for: Multiple Myeloma, Metastatic Cancer, Pagets Disease Osteoporosis

How long have you been on bisphosphonate therapy:

Do you smoke ? Yes No If "Yes" How long for? How many packet/day

Do you chew tobacco ? Yes No If "Yes" How long for? How many packet/day

Do you drink alcohol ? Yes No If "Yes" How often? How much

**Women only:**

Are you Pregnant? : Yes No Maybe Are you Nursing? : Yes No

Are you taking birth control pills? Yes No Menopause: Yes No

**ORAL HEALTH HISTORY**

Why have you come to the dentist today?

Date of your last dental check up Date of your last dental X-ray

Your previous Dentist: Address:

Why did you leave your previous dentist

Are you happy with your Smile? Yes No If "No", why ?

Do you have or had braces in the past? Yes No

Have you had history of periodontal disease? Yes No If "Yes", how long ago

Has fear or anxiety been an issue for you in dental office Yes No If "Yes" please explain

Please mark "Yes" if you have or have had, or mark "No" if you have not had any of the following conditions.

Condition	Yes	No	Condition	Yes	No	Comments (office use only)
Abscess			Pain around ears			
Bleeding gum			Clicking/popping/locking jaw			
Loose teeth			Grinding teeth			
Swollen gum			Pain in jaw/face/neck			
Discolored teeth			Surgery in the jaw			
Dry mouth			Burning sensation in mouth			
Bad breath			Sensitivity to cold			

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by Dr. Habibian and her staff to help determine appropriate dental treatment. If there is any change in my medical status, I will inform Dr. Habibian and her staff. Please sign and date your General and Oral Health History required by law.  
 Name (Patient/ Parent/ Guardian): Date:

Signature (Patient/Parent/ Guardian): \_\_\_\_\_

**Please bring the complete form when you come for your appointment.  
 Thank you for your cooperation**