



Aurora Dental Care Health History Form

Patient Name: _____ Date: _____

Are you under a physician's care? Yes No

Physician's Name _____ Phone Number _____

Prescriptions or Non-prescription medication:
(List below & attach sheet if necessary)

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

<p>Allergies (check all that apply)</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> Aspirin</td> <td><input type="checkbox"/> Erythromycin</td> <td><input type="checkbox"/> Metals</td> </tr> <tr> <td><input type="checkbox"/> Codeine</td> <td><input type="checkbox"/> Jewelry</td> <td><input type="checkbox"/> Penicillin</td> </tr> <tr> <td><input type="checkbox"/> Dental Anesthetics</td> <td><input type="checkbox"/> Latex</td> <td><input type="checkbox"/> Tetracycline</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Sulfur Drugs</td> <td></td> </tr> </table> <p>List other allergies: _____</p>	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Metals	<input type="checkbox"/> Codeine	<input type="checkbox"/> Jewelry	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Dental Anesthetics	<input type="checkbox"/> Latex	<input type="checkbox"/> Tetracycline		<input type="checkbox"/> Sulfur Drugs		<p>Women Only:</p> <input type="checkbox"/> Are you taking Birth Control Pills? <input type="checkbox"/> Are you Pregnant (# wks _____) <input type="checkbox"/> Are you nursing?
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Metals											
<input type="checkbox"/> Codeine	<input type="checkbox"/> Jewelry	<input type="checkbox"/> Penicillin											
<input type="checkbox"/> Dental Anesthetics	<input type="checkbox"/> Latex	<input type="checkbox"/> Tetracycline											
	<input type="checkbox"/> Sulfur Drugs												

Do you require Antibiotics before dental treatment? Yes No

For the following section please check yes or no. Do you or have you experienced the following?

Yes	No		Yes	No		Yes	No		Yes	No				
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Chemo Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	Shingles
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart defect	<input type="checkbox"/>	<input type="checkbox"/>	HIV+ AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	<input type="checkbox"/>	Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Cosmetic Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Steroid Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Bones/Joints	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart/Valves	<input type="checkbox"/>	<input type="checkbox"/>	Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Herpes/ Fever Blister	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic (Scarlet) Fever	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease

List any other serious medical conditions you have experienced

DENTAL HISTORY

Are you currently in pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you experienced problems associated with any previous dental work?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you now or have you ever experienced pain/discomfort in your jaw joint?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you brush your teeth daily?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you floss daily?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do your gums ever bleed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had periodontal disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Previous Dentist _____	Date of last visit: _____	
Are you happy with the way your smile looks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If not, what would you change? _____		
Why did you leave your previous dentist? _____		
Do you smoke or chew tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

GENERAL QUESTIONS

Who can we thank for referring you today? _____	
What is most important to you about your teeth?	<input type="checkbox"/> Function <input type="checkbox"/> Health <input type="checkbox"/> Looks
What would be your chief complaint about your smile today? _____	
What problem would you MOST like to address today? _____	
Would you be interested in	
▪ Cosmetic Dentistry?	<input type="checkbox"/> Yes <input type="checkbox"/> No thank you
▪ Porcelain Veneers?	<input type="checkbox"/> Yes <input type="checkbox"/> No thank you
▪ Straightening your teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No thank you
▪ Can I speak with you about Invisalign (invisible braces)?	<input type="checkbox"/> Yes <input type="checkbox"/> No thank you
▪ Whitening your teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No thank you
I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform Aurora Dental Care of any change in my medical status	
_____ Signature	_____ Date
Aurora Dental Care Use: Notes from First Appointment	