IMPRESSIONS DENTAL

5970 S. Cooper Rd. Ste #1 Chandler, AZ 85249 (480)814-8888

Health History Form

Patient's Full Name: ____

Reason for today's visit____

Former Dentist______________________City/State______________________

Date of last dental visit__________________ Date of last dental x-ray__________________

How often do you floss? How often do you brush? Do you require a pre-medication?

Check all that apply

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Blisters/sores/growths on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Cigarette/pipe/cigar smoking
- ☐ Clicking or popping jaw
- ☐ Dry mouth
- ☐ Foreign objects
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Gums swollen or tender
- ☐ Jaw pain
- ☐ Jaw tiredness
- ☐ Lip or cheek biting
- ☐ Loose teeth/broken fillings
- ☐ Fingernail biting
- ☐ Mouth pain, brushing
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Mouth breather
- ☐ Have you ever been diagnosed with Sleep Apnea?
- ☐ Have you ever had an overnight sleep study?
- ☐ Do you or have you used a CPAP?
- ☐ Do you wake up in the morning with headaches?
- ☐ Have you been told that you gasp for air or suddenly stop breathing while sleeping?
- ☐ Do you snore?

Health History

Physician's Name ____________ Date of Last Visit__________ Other Medical Conditions not listed below______________________

Have you ever taken any medications containing bisphosphonates? This includes brands such as Fosamax, Actonel, Didronel, Boniva, Aredia, and Zometa. ☐ Yes ☐ No

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Auto-Immune Diseases
- ☐ Back Problems
- ☐ Bleeding abnormally, with extractions or surgery
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, persistent/bloody
- ☐ Diabetes
- ☐ Dizziness/ Fainting
- ☐ Bone Density medication
- ☐ Cholesterol medication
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Acidreflux/Gerd
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis Type ______
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Medical Marijuana/Recreational Use
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Recreational Drug Use
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Feet/Ankles
- ☐ Swollen Neck Glands
- ☐ Tabacco Use Length of use:
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or growth on head or neck
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Weight Loss/Gain

Do you wear contact lenses? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Due Date: ______________

Are you nursing? ☐ Yes ☐ No

Medication

List any medication you are currently taking and the correlating diagnosis: ______________

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Allergies

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other____________

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I authorize and give consent to perform dental services agreed between Impressions Dental and its associates and patient and/or parent or guardian to be necessary or advisable including the use of anesthesia and other medication as indicated. I certify to the accuracy of the above statements regarding my medical and dental history. Payment for all treatment and services rendered are my responsibility.

______________________ ______________________ ____________

Signature of patient, parent, guardian or personal representative | Printed name of patient, parent, guardian or personal representative | Date