Miles 2 Smiles, LLC

Mobile Dental Hygiene Services

Kyle Isaacs, EPDH

541-740-4694, kjulin@gmail.com

HEALTH HISTORY for: Name___________________________________Date____________

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

(Please check any that apply)

❑ Cancer or tumor
❑ Shortness of Breath
❑ Congenital heart disease
❑ Heart ailment, angina, or chest pain
❑ Heart murmur, mitral valve prolapse, heart defect
❑ Artificial heart valve
❑ Heart pacemaker
❑ Stroke
❑ Hypoglycemia
❑ Ulcers
❑ Gout
❑ Intestinal issues
❑ Kidney problems
❑ Thyroid issues
❑ Emphysema or COPD
❑ Tuberculosis
❑ Sinus issues
❑ Radiation therapy
❑ Chemotherapy
❑ Heart surgery
❑ Arteriosclerosis
❑ Rheumatic fever or rheumatic heart disease
❑ Artificial joint or valve
❑ High or low blood pressure
❑ Pacemaker
❑Hepatitis or other liver disease
❑ Alcoholism or drug addiction
❑Blood transfusion
❑Diabetes
❑ Neurologic condition
❑ Epilepsy, seizures, or fainting spells
❑ Emotional condition
❑ Arthritis
❑ Herpes or cold sores
❑ Glaucoma
❑ Dementia
❑ Special diet
❑ Unexplained gain or loss of weight
❑ Migraine headaches or frequent headaches
❑ Anemia or blood disorders
❑ Abnormal bleeding after extractions, surgery, or trauma
❑ Hay fever or sinus trouble
❑ Allergies or hives
❑ Asthma
❑ Immunocompromised
❑ Acid Reflux

Have you been hospitalized in the last two years? If so why? Any other health issues?

____

____

Medications:___________________________

____

____

____

____

Do you smoke or use chewing tobacco?

❑ yes ❑ no

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Are you allergic to, or have you reacted adversely to any of the following?

❑ Latex materials
❑ Penicillin or other antibiotics
❑ Local anesthetics ("Novocain")
❑ Codeine or other narcotics
❑ Sulfa drugs
❑ Barbiturates, sedatives, or sleeping pills
❑ Aspirin
❑ Food
❑Other:_______________________________

Are you taking any of the following?

❑ Aspirin
❑ Anticoagulants (blood thinners)
❑ Antibiotics or sulfa drugs
❑ High blood pressure medicine
❑ Antidepressants or tranquilizers
❑ Insulin or other diabetes medication
❑ Nitroglycerin
❑ Cortisone or other steroids
❑ Osteoporosis (bone density) medicine
❑ Other: ______________________________

Women:

❑ May be pregnant
❑ Expected delivery date: _____________
❑ Taking hormones or contraceptives

Is Patient required to take antibiotics before dental treatment? ❑ YES ❑ NO

If yes, for what condition?

____

What antibiotic?

____

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

____

____

Please add anything else you would like us to know about:

____

____

DENTAL HISTORY

❑Apprehensive about dental treatment
❑Bleeding when brushing
❑Wisdom tooth extractions
❑Swollen gums
❑Periodontal disease
❑Slow-healing sores in your mouth
❑Orthodontics
❑Sensitive teeth
❑Problems with previous dental treatment
❑Cold sensitivity
❑Dentures or partial dentures
❑Heat sensitivity
❑Treatment for jaw trauma/fracture
❑Pain in the jaw joint
❑Bleeding gums
❑Difficulty opening or closing
❑Clenching or grinding
❑Sensitivity to biting
❑Noise or popping in the jaw
❑Sensitive to sweets
❑ Earaches or pain in front of the ears
❑Difficulty chewing
❑History of TMJ issues
❑Gag easily

Date of last dental cleaning_____________

Previous bad dental experiences?

____

Any present dental concerns?

____

Signature of patient, parent, or guardian

____

Date__________________________________