Joshua Nellis, DDS
THE WOODLANDS DENTIST

HEALTH HISTORY

Patient Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

	YES	NO
Are you in good health	☐	☐
Have there been any changes in your general health within the past year	☐	☐

Date of your last physical exam _____

Physician's name _____

Address _____

Phone no. _____

	YES	NO
Are you now under the care of a physician	☐	☐
Have you ever been hospitalized for any surgical operation or serious illness	☐	☐

Please explain _____

	YES	NO
Are you taking any medicine(s) including non-prescription medicine	☐	☐

If yes, what medications are you taking and for what condition?

	YES	NO
Have you had any abnormal bleeding	☐	☐
Do you bruise easily	☐	☐
Have you ever required a blood transfusion	☐	☐
Have you had a recent weight loss	☐	☐
Have you ever taken fen-phen/redux	☐	☐
Do you use tobacco	☐	☐
Do you or have you used controlled substances	☐	☐
Are you wearing contact lenses	☐	☐
Do you have any disease, condition or problem not listed above that you think I should know about	☐	☐
Do you have any metal rods, plates, or screws	☐	☐

Women only:

	YES	NO
Are you pregnant or think you may be pregnant	☐	☐
Are you nursing	☐	☐
Are you taking birth control pills	☐	☐

Are You Allergic To Or Have You Had Reactions To:

	YES	NO
Local Anesthetics like Novocaine	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates, Sedatives, or Sleeping Pills	☐	☐
Aspirin	☐	☐
Iodine	☐	☐
Any Metals (e.g., Nickel, Mercury, Etc.)	☐	☐
Latex/Rubber	☐	☐

Other (please list) _____

Do You Have Or Have You Ever Had The Following:

	YES	NO
Rheumatic Heart Disease or Rheumatic Fever	☐	☐
Scarlet Fever	☐	☐
Heart Defect or Heart Murmur	☐	☐
Heart Trouble, Heart Attack or Angina	☐	☐
Chest Pain	☐	☐
Shortness of Breath	☐	☐
Pacemaker	☐	☐
Heart Surgery	☐	☐
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Congenital Heart Problem	☐	☐
Swelling of Feet, Ankles, Hands	☐	☐
Hepatitis, Jaundice Or Liver Disease	☐	☐
Stroke	☐	☐
Sinus Trouble	☐	☐
Lung or Breathing Problems	☐	☐
Asthma or Hay Fever	☐	☐

	YES	NO
Hives or Skin Rash	☐	☐
Fainting or Dizzy Spells	☐	☐
Diabetes	☐	☐
Hypoglycemia	☐	☐
AIDS or HIV Infection	☐	☐
Thyroid Problems	☐	☐
Allergies	☐	☐
Arthritis or Rheumatism	☐	☐
Joint Replacement or Implant	☐	☐
Stomach Ulcer	☐	☐
Kidney Trouble	☐	☐
Tuberculosis	☐	☐
Persistent Cough	☐	☐
Cough that Produces Blood	☐	☐
Chemotherapy (Cancer / Leukemia)	☐	☐
Sexually Transmitted Disease	☐	☐
Epilepsy or Seizures	☐	☐
Anemia	☐	☐
Glaucoma	☐	☐
Nervousness	☐	☐
Tonsillitis	☐	☐
Tumors	☐	☐
Mental Health Care	☐	☐
Back Problems	☐	☐
Mitral Valve Prolapse	☐	☐
Cortisone Treatments	☐	☐
Cold Sores/fever Blister	☐	☐
Eating Disorders	☐	☐

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HEALTH HISTORY

Patient Dental History

Patient's Name _____ Date of Birth _____

Reason for this visit _____

When was your last dental visit? _____ What was done? _____

Previous Dentist Name (name and location) _____

Have you had any dental x-rays taken in the last 6 months? _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

	YES	NO
Do your gums bleed while flossing or brushing?	☑	☑
Do you feel pain with any of your teeth?	☐	☐
Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
Does food tend to become caught between your teeth?	☐	☐
Have you had any head, neck or jaw injuries?	☐	☐
Have you ever experienced any of the following problems in your jaw:		
Clicking	☐	☐
Pain (Joint, Ear, Side of Face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
Do you have frequent headaches	☐	☐
Do you clench or grind your teeth	☐	☐

	YES	NO
Do you snore or have you been told you snore?	☐	☐
Have you been diagnosed with sleep apnea?	☐	☐
Do you use a CPAP machine or have you been told you need a CPAP machine?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐
Have you noticed any loosening of your teeth?	☐	☐
Have you ever had periodontal treatment (gums)?	☐	☐
Ever worn a night guard or splint?	☐	☐
Have you ever had any prolonged bleeding following extractions?	☐	☐
Do you wear dentures or partials?	☐	☐
If yes, date of placement	_____	

Is there anything about your smile you don't like? _____

Do you like the appearance of your smile? _____

Are your teeth all in alignment (straight)? _____

Do you have missing teeth? _____ Are any chipped? _____

Is your bite comfortable for chewing, biting? _____

Do you have frequent headaches? _____

Do you have old fillings or dental work you don't like? _____

What would you like to change the most in the appearance of your teeth? _____

Are you aware of the new techniques in dentistry? _____

What is most important to you in a dental office _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The questions have been accurately answered, I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient/Parent/Guardian _____ Date _____