

Stuart V. Corso, D.M.D.
Health History Form

Patient Name: _____

Dental History: (Complete this section if new patient)

Reason for today's visit _____ Date of last dental visit: _____

Former Dentist _____ Date of last dental x-rays _____

Check if you have had problems with any of the following:

<input type="checkbox"/> Bad breath	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Sensitivity to hot
<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Loose teeth or broken fillings	<input type="checkbox"/> Sensitivity to sweets
<input type="checkbox"/> Clicking or popping jaw	<input type="checkbox"/> Periodontal treatment	<input type="checkbox"/> Sensitivity when biting
<input type="checkbox"/> Food collection	<input type="checkbox"/> Sensitivity to cold	<input type="checkbox"/> Sores or growth in mouth
<input type="checkbox"/> Use tobacco products	<input type="checkbox"/> Dry mouth	<input type="checkbox"/> Pain around ear

Do you require pre-medication? Yes No

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

Medical History:

Physician's Name _____ Phone _____

Have you had any serious illnesses or operations? Yes No

If yes, describe _____

Have you ever had a blood transfusion Yes No If yes, approximate dates _____

(Women) Are you pregnant? Yes No Nursing? Yes No Oral Contraceptives? Yes No

Check if you have or have had any of the following:

<input type="checkbox"/> Anemia	<input type="checkbox"/> Cortisone Treatments	<input type="checkbox"/> Hepatitis Type _____
<input type="checkbox"/> Arthritis/Rheumatism	<input type="checkbox"/> Cough, Persistent (3 weeks)	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Artificial Heart Valves	<input type="checkbox"/> Cough Up Blood	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Jaw Pain
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Fainting/Dizziness	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Excessive Bleeding
<input type="checkbox"/> Cancer	<input type="checkbox"/> Headaches	<input type="checkbox"/> Pacemaker/Auto Defib
<input type="checkbox"/> Drug/Alcohol Addiction	<input type="checkbox"/> Heart Murmur/MVP	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Respiratory Disease
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Skin Rash
<input type="checkbox"/> Swelling of Feet or Ankles	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Tobacco Habit
<input type="checkbox"/> Tonsilitis	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Herpes
<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Tumor or growths on head or neck	<input type="checkbox"/> Sinus Trouble

Medications:

List any medications you are currently taking: _____

Allergies:

Please check if you have allergies to any of the following:

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Latex	<input type="checkbox"/> Other (please list) _____
<input type="checkbox"/> Codeine	<input type="checkbox"/> Penicillin	_____
<input type="checkbox"/> Sulfa	<input type="checkbox"/> Metals including jewelry	_____

Pharmacy you use _____ **Phone** _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Signature of Patient/Guardian _____ **Date** _____

RECALL REVIEW:

1. Patient's signature _____ Date _____
2. Patient's signature _____ Date _____
3. Patient's signature _____ Date _____