# Health History Information

ATLAS DENTAL SPECIALISTS
355 5th Ave Suite 1520
Pittsburgh, PA 15222
412.281.4911

Name: _____ Date of Birth: _____ Today's Date: _____

Reason for today's visit: ___ Examination ___ Emergency ___ Consultation

Please indicate any of the following problems and explain below:

__ Toothache
__ Broken/chipped tooth
__ Lost/broken filling
__ Loose/shifting teeth
__ Food caught between teeth
__ Stained teeth
__ Sensitivity to: __ Hot __ Cold __ Sweets __ Biting/chewing
__ Gum disease
__ Red, swollen, bleeding gums
__ Bad breath
__ Blisters/sores in mouth
__ Swelling/lumps in mouth
__ Recent infections or sore throat
__ Pain/clicking/popping of jaw
__ Tooth grinding/clenching
__ Jaw locks open/closed
__ Headaches/ringing in ears
__ History of head/neck injury
__ Removable dental appliance
__ Other/explanation: _____

What type of toothbrush do you use? __ Electric __ Manual __ Soft __ Medium __ Hard
Last dental exam: _____ How many times a day do you brush? _____
Last dental X-rays: _____ How many times a week to you floss? _____

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (best)
Would you like whiter teeth? __ Yes __ No

Do you have a specific dental problem? Explain: _____
Do you smoke or chew tobacco? __ Yes __ No
Do you have dental anxiety? __ Yes __ No
Name of previous dentist (optional): _____

Have you been diagnosed with a sleep disorder? __ Yes __ No
Has anyone told you that you snore? __ Yes __ No
Do you feel tired or fatigued during the day? __ Yes __ No
Do you notice that your mouth is dry at any time, day or night? __ Yes __ No

Are you under the care of a physician, and if so who? _____ Why? _____
Have you been hospitalized or had any major surgery in the last 5 years? _____

Please list all medications: _____

Are you allergic to any of the following medications or substances? (Please circle):
Aspirin Penicillin Codeine Acrylic Metal Latex Other:_____

Do you have now, or have you ever been diagnosed with any of the following conditions: (Check all that apply)

___ Allergies
___ Anemia
___ Angina/chest pain
___ Artificial joint
___ Asthma
___ Breathing problem
___ Bruise easily
___ Bleeding disorder
___ Cancer: _____
___ Chemotherapy
___ Cold sores
___ Coronary stent
___ Diabetes
___ Endocarditis
___ Epilepsy or seizures
___ Fainting/dizziness
___ Heart attack/failure
___ Heart murmur or defect
___ Heart surgery
___ Hepatitis A, B, or C
___ High blood pressure
___ HIV/AIDS
___ Irregular heart beat
___ Kidney problems
___ Liver disease
___ Lung disease
___ Mitral valve prolapse
___ Osteoporosis
___ Pacemaker
___ Radiation treatment
___ Sinus trouble
___ Stroke
___ Stomach/Intestinal disease
___ Other: _____

To the best of my knowledge, all the answers given are correct. Should a change in my medications occur, I will notify the dentist.

X _____ Date: _____ *Reviewed by: _____ Date Reviewed: _____*