PAUL MIKHLI, DDS
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HEALTH HISTORY FORM

Today's Date ____________________

Patient Name ____ Date of Birth _____/_____/_______

What is the reason for your visit? ____

Last dental visit? ____________________ What service was performed? ____________________

Previous dentist name? ____

How often do you brush? ____

Do you use a power brush? ☐ Yes ☐ No

Have you ever been told you have gum disease? ☐ Yes ☐ No

What do you use to clean between your teeth? ☐ Floss ☐ Proxy Brush ☐ Soft Picks ☐ Other _____

Do you have any type of dental appliance? ☐ Yes ☐ No

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

☐ Bleeding, sore gums
☐ Unpleasant taste/bad breath
☐ Frequent blisters, lips/mouth
☐ Clicking/popping jaw
☐ Difficulty opening or closing jaw
☐ Missing teeth
☐ Loose teeth
☐ Sensitive to hot
☐ Sensitive to cold
☐ Sensitive to sweets
☐ Sensitive when chewing
☐ Clenching/grinding teeth
☐ Sinus trouble
☐ Frequent headaches/Migraines
☐ Snoring
☐ Sleep apnea
☐ Dry mouth

Have you ever had difficulty with previous dental treatments? ______________________________

____

Are you happy with your smile? ☐ Yes ☐ No

Would you like to improve the color of your teeth? ☐ Yes ☐ No

Would you like to improve the size/shape of your teeth? ☐ Yes ☐ No

Would you like to improve the alignment of your teeth? ☐ Yes ☐ No

Do you play sports? ☐ Yes ☐ No

Have you had excessive bleeding requiring special treatment? ☐ Yes ☐ No

Primary Care Physician:

Name: ____

Address: ____

City, State, Zip: _______________________________________

Phone: ____

Have you ever been hospitalized? ☐ Yes ☐ No For what? ______________________

Do you smoke or use smokeless tobacco? ☐ Yes ☐ No

How often? ____

Over

What medications are you currently taking? Please list and state what they are for?

______________________ ______________________
______________________ ______________________
______________________ ______________________

Have you been advised to take antibiotics prior to dental treatment? ☐ Yes ☐ No

Are you allergic to any medications? ☐ Yes ☐ No

- ☐ Penicillin
- ☐ Codeine
- ☐ Aspirin
- ☐ Anesthetics
- ☐ Latex
- ☐ Other ______________________

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

- ☐ Heart disease
- ☐ Heart attack
- ☐ Artificial heart valve
- ☐ Pacemaker
- ☐ High blood pressure

(If so what do you do to control it)

____

- ☐ Chest pains or angina
- ☐ Stroke
- ☐ Artificial joint
- ☐ Hepatitis/Liver disease (A, B, C)
- ☐ Tuberculosis
- ☐ Thyroid trouble
- ☐ Kidney disease
- ☐ Diabetes (Type 1 or 2)
- ☐ Asthma (Do you carry an inhaler with you) ☐ Yes ☐ No
- ☐ HIV or other immunosuppressive disease
- ☐ Radiation or Chemotherapy
- ☐ Seizures
- ☐ Psychiatric treatment
- ☐ Treatment for Osteoporosis

Do you have any other disease or condition not listed here? ☐ Yes ☐ No

____
____

For Women:

Are you pregnant? ☐ Yes ☐ No Due date? ______________________

Are you currently nursing? ☐ Yes ☐ No

Are you currently taking Birth Control pills? ☐ Yes ☐ No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X ______________________ Date ______________________

Patient or guardian signature

Updates: