(205) 988 - 4470
NickBrownDental.com

DR. NICK BROWN DENTAL CARE

2041 Valleydale Road
Birmingham, AL 35244

HEALTH HISTORY

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Dental Information

	Yes	No
Have you ever had orthodontic (braces) treatment?	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐
Do you wear removable dental appliances?	☐	☐
Have you ever had an upsetting dental visit?	☐	☐

Date of your last dental exam: _____

Date of last dental x-rays: _____

What was done at that time? _____

Smile Assessment

Please consider each statement carefully and circle YES or NO.
The doctor and team members will be happy to discuss your responses with you in confidence.

1. I have concerns about the appearance of my teeth or my smile.
   YES NO
2. I have concerns about the whiteness/lack of whiteness of one or more of my teeth.
   YES NO
3. I have concerns about the position or angle of one or more of my teeth.
   YES NO
4. I have concerns about the shape of one or more of my teeth.
   YES NO
5. I have old fillings or previous dental treatment that is no longer satisfactory to me.
   YES NO
6. I often cannot eat or chew the food that I used to enjoy.
   YES NO
7. I have sensitivity when I eat or drink something hot/cold.
   YES NO
   If yes, please rate the level of sensitivity:
   Least 1 2 3 4 5 Most
8. I grind my teeth.
   YES NO
9. My gums sometimes hurt or bleed when I brush/floss.
   YES NO
10. Is there anything about your teeth that you would like to change?
    YES NO

What brings you to our office today?

Please use the space below to indicate any other problems, concerns or questions you have. We will be happy to discuss those concerns with you so that we can present you with the best possible treatment options. _____

Medical Information

If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.

Have you had any of the following diseases or problems?

	Yes	No
Active Tuberculosis	☐	☐
Persistent cough greater than a 3-week duration	☐	☐
Cough that produces blood	☐	☐

Please list all medications you are currently taking (Prescribed, Over the Counter, Vitamins, natural or herbal preparations, and/or diet supplements).

_____
_____
_____
_____

	Yes	No
Are you now under the care of a physician?	☐	☐

If yes, what is/are the condition(s) being treated? _____

Have you had any serious illness, operation, or been hospitalized in the past 5 years?	☐	☐

If yes, what was the illness or problem? _____

Are you alcohol and/or drug dependent?	☐	☐
If yes, have you received treatment?	☐	☐
Do you use tobacco (smoking, snuff, chew)?	☐	☐

If yes, how interested are you in stopping?
(circle one) Very / Somewhat / Not interested

Medical Information (cont.)

Please check all of the following that you are allergic to or have had a reaction to.

- Local anesthetics ☐
- Aspirin ☐
- Penicillin or other antibiotics ☐
- Sulfa drugs ☐
- Codeine or other narcotics ☐
- Latex ☐
- Iodine ☐
- Other: _____

_____

_____

	Yes	No
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐

If yes, what antibiotic and dose? _____

Name of physician or dentist: _____

Phone: _____

Women Only

Are you or could you be pregnant?	☐	☐
If yes, expected due date: _____		
Nursing?	☐	☐
Taking birth control pills or hormonal replacement?	☐	☐

Do you have any of the following conditions? Please check all that apply.

- Abnormal bleeding ☐
- AIDS or HIV infection ☐
- Anemia or blood disorder ☐
- Asthma ☐
- Blood transfusion, if so, date: _____ ☐
- Cancer/Chemotherapy/Radiation Treatment ☐
- Cold sores ☐
- Congenital heart defects ☐
- High blood pressure ☐
- Low blood pressure ☐
- Mitral valve prolapse ☐
- Pacemaker ☐
- Diabetes, if yes, specify below: ☐
  - ☐ Type I (insulin dependent) ☐ Type II
- TMJ Disease ☐
- Epilepsy ☐
- Fainting spells or seizures ☐
- Hepatitis, jaundice, or liver disease ☐
- Mental health disorders ☐
  - If yes, specify: _____
- Neurological disorders ☐
  - If yes, specify: _____
- Respiratory problems ☐
  - If yes, specify: (Emphysema, Bronchitis, etc.)

_____

- Severe headaches/migraines ☐
- Allergies or sinus trouble ☐
- Sores or ulcers in the mouth ☐
- Ulcers ☐

Do you have any diseases, conditions, or problems not listed above that you think I should know about?
Please explain:

_____

_____

_____

Note: Both Doctor and patient are encouraged to discuss any and all relevant health issues prior to treatment.
I certify that have read and understand the above. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff, responsible for action they take or do not take because of errors or omissions that I may have made in the completion of this form. I will notify the doctor of any change in my health or medication.

Signature of Parent/Legal Guardian _____ Date _____

For Completion By Dentist

Comments on patient interview concerning health history: _____

_____

Significant findings from questionnaire or oral interview: _____

_____

Dental management considerations: _____

_____

Health History Update: On a regular basis the patient should be questioned about any medical history changes, date and comments notated, along with signature.