Todd S. Johnson, DDS

Health History

The information provided on this form is important to your dental health. If you have any questions, please don't hesitate to ask.

Patient Name:_____ DOB:_____ Today's Date_____

Family Physician:_____

Do you have or have you had any of the following? Please check "YES" or "NO".

Heart Problems:

High or Low Blood Pressure..... ◯ YES ◯ NO
Heart Murmur or Mitral Valve Prolapse..... ◯ YES ◯ NO
Artificial Valve, Pacemaker or Stent..... ◯ YES ◯ NO
Stroke..... ◯ YES ◯ NO
Heart Attack or Angina Pectoris..... ◯ YES ◯ NO
Heart Medications or Nitroglycerin..... ◯ YES ◯ NO

Blood Problems:

Easy Bruising..... ◯ YES ◯ NO
Abnormal Bleeding..... ◯ YES ◯ NO
Blood Thinners (Coumadin, Plavix or Aspirin)..... ◯ YES ◯ NO
Circulatory Problems..... ◯ YES ◯ NO
Hemophilia..... ◯ YES ◯ NO
Low Blood Sugar or Anemia..... ◯ YES ◯ NO

Respiratory Problems:

Asthma, Emphysema or Tuberculosis..... ◯ YES ◯ NO
Chronic Bronchitis..... ◯ YES ◯ NO
Sinus Troubles..... ◯ YES ◯ NO
Frequent or Severe Headaches..... ◯ YES ◯ NO
Fainting Spells, Seizures or Epilepsy..... ◯ YES ◯ NO

Bone or Joint Problems:

Joint Replacement..... ◯ YES ◯ NO
Implants..... ◯ YES ◯ NO
Arthritis or Osteoporosis (Please circle)..... ◯ YES ◯ NO
Taking Bisphosphonates (Fosamax, Boniva)..... ◯ YES ◯ NO
Taking Corticosteroids..... ◯ YES ◯ NO

Daily Medications (including over the counter) – or attach list

_____
_____
_____
_____
_____

Allergic Reactions:

Antibiotics (Penicillin or Other)..... ◯ YES ◯ NO
Aspirin, Acetaminophen, or Ibuprofen..... ◯ YES ◯ NO
Latex (Allergy or Sensitivity)..... ◯ YES ◯ NO
Other Allergies: _____
_____

Diabetes..... ◯ YES ◯ NO
Current A1C: _____ Date:_____

Cancer (Chemotherapy or Radiation)..... ◯ YES ◯ NO
Tumors or Benign Growths..... ◯ YES ◯ NO
Any Physical Limitations..... ◯ YES ◯ NO
Hearing or Sight Disability..... ◯ YES ◯ NO
Glaucoma or Contact Lenses..... ◯ YES ◯ NO
Psychiatric Treatment..... ◯ YES ◯ NO
Depression or Anxiety Disorders..... ◯ YES ◯ NO
HIV or AIDS..... ◯ YES ◯ NO
Hepatitis A, B or C..... ◯ YES ◯ NO
Liver or Kidney Issues..... ◯ YES ◯ NO
Drug or Alcohol Abuse Issues..... ◯ YES ◯ NO
Smoke or Chew Tobacco..... ◯ YES ◯ NO
Are you pregnant?..... ◯ YES ◯ NO
Taking Hormonal Contraceptives? ..... ◯ YES ◯ NO
If yes, which:_____
Are you taking hormones/HRT?..... ◯ YES ◯ NO

Sleep:

Snoring..... ◯ YES ◯ NO
Sleep Apnea / CPAP..... ◯ YES ◯ NO
GERD / Acid Reflux..... ◯ YES ◯ NO

Recent Surgeries_____
_____

Have you been under the care of a physician during the past two years? If yes explain:

_____
_____

The above information is true and correct to the best of my knowledge.

_____ _____

Patient Signature ***Date***

We request that you update this form at each visit, please sign and date below when update is completed.

_____ _____ _____ _____

DATE PATIENT SIGNATURE DATE PATIENT SIGNATURE

Todd S. Johnson, DDS

Dental History

Patient Name:_____ DOB:_____ Today's Date_____

Previous Dentist:_____Last Visit:_____

What specific dental concerns do you have now? _____

Please mark any questions that you would answer "YES".

- ☐ Are you here today because of an emergency / pain?
- ☐ Do you experience dental anxiety?
- ☐ Are you interested in Nitrous or alternative sedation options for dental treatment?
- ☐ Any issues with previous dental treatment? *(Please explain)*

  _____
- ☐ Do you have sore, tender, or bleeding gums?
- ☐ Have you been diagnosed gingivitis or periodontal disease?
- ☐ Do you have your teeth cleaned more than twice per year?
- ☐ Have you seen a periodontal specialist for treatment?
- ☐ Are your teeth sensitive? And to what? (Check below)
  - ☐ Hot or cold foods / liquids _____
  - ☐ Biting _____
  - ☐ Other _____
- ☐ Are you missing teeth other than wisdom teeth?
- ☐ Do you wear partials or have dentures?
- ☐ Do you have any dental implants?
- ☐ Does food catch in your teeth?
- ☐ Do you have any loose teeth?
- ☐ Have you had orthodontic treatment? (Braces, Invisalign, etc.)
- ☐ Still wearing retainers?
- ☐ Do you clench or grind your teeth frequently?
  If yes ☐ Daytime ☐ Nighttime ☐ Other _____
- ☐ Do you wear a nightguard / bite guard?
- ☐ Do you wear a sports guard when playing sports?
- ☐ Have you been diagnosed with TMJ or TMD?
- ☐ Do you have headaches or jaw symptoms on wakening?
  If yes, how frequently? _____
- ☐ Do you have pain in your face, jaw, neck, or temples?
- ☐ Have you had any jaw or facial trauma? *(Please explain)*

  _____
- ☐ Is there anything you would change about your teeth?
  - ☐ Color ☐ Shape ☐ Spaces ☐ Alignment
  - ☐ Other _____

Do you require "Premedication" with an antibiotic prior to dental treatment? ◯ YES ◯ NO

If yes, reason for antibiotic premed: _____

_____

What is your estimate of your dental health? ◯ Good ◯ Fair ◯ Poor

How often do you brush and floss? _____

What statement best describes the treatment you are seeking?

- ☐ Just want to avoid pain.
- ☐ Want to keep my teeth functional and healthy.
- ☐ Want to keep my teeth functional, healthy, and good looking.

Anything else we should know? _____