DIAMOND DENTAL OF OWINGS MILLS, LLC

Monica M. Mattson, D.D.S.

HEALTH HISTORY (Confidential)

Name: _____ Today's Date: _____
Birth Date: _____ Date of Last Dental Exam: _____ X-Rays: _____
What is the reason for your visit? _____
Do you consider yourself in good health? _____ Physician: (name/contact info) _____
Are you happy with your smile? _____ _____
Have you ever smoked or used tobacco (circle) products?___ How long? ____ Qty/day? _____
Do you still smoke or use tobacco (circle) products? _____ How long? ____ Qty/day? _____
Have you ever had an oral cancer exam? _____
Are you pregnant? _____ How many weeks? _____
Do you suffer from migraines or muscle tension headaches? _____ How often? _____
Are you aware of clenching or grinding of your teeth? _____ Have you worn/wear (circle) a nightguard? _____
Do you have a history of periodontal (gum) disease?_____
Have you ever had "deep cleanings" or root planing of your teeth? _____ When? _____
Have you ever been pre-medicated before dental appointments? _____ Antibiotics? _____ Anxiety? _____
Do you have a dry mouth? _____
Do you drink sodas or sports drinks? _____ How often?_____
Do you chew gum, chew ice, bite nails, suck on hard candy or cough drops (circle)? _____ How often?_____
Do you get fever blisters or cold sores? _____ How often?_____
Are there any other health issues we should know about? _____
Health History Updates _____ _____ _____ _____ _____ _____ _____ _____ _____

CONDITIONS: Circle Conditions that you HAVE or HAD in the past.

Condition	Please Explain	Condition	Please Explain
Acid Reflux/GERD	_____	Herpes	_____
AIDS	_____	High Blood Pressure	_____
Alcoholism	_____	AIDS / HIV Positive	_____
Anorexia	_____	HPV	_____
Asthma/Inhaler	_____	Joint Replacement/Date	_____
Bleeding Disorder	_____	Kidney Disease	_____
Blood Transfusion	_____	Liver Disease	_____
Bulimia	_____	Migraine Headaches	_____
Chemical Dependence	_____	Pacemaker/Defibrillator Implant	_____
Cancer/Type/Treatment	_____	Psychiatric Care/Medication	_____
Diabetes/Type/Controlled?	_____	Subacute Bacterial Endocarditis	_____
Emphysema	_____	Stroke / T.I.A.	_____
Epilepsy	_____	Thyroid Problems	_____
Heart Disease	_____	Tuberculosis	_____
Heart Murmur	_____	Ulcers	_____
Hepatitis/Type	_____	Other	_____

Patient is responsible for notifying the dentist of any changes in their health or medications. Initials___

MEDICATIONS: (List of medication and dosages currently taking) _____
_____
VITAMINS, SUPPLIMENTS, RECREATIONAL DRUGS: (What and how often)_____
_____
ALLERGIES: (To medications or substances)_____
_____
Do you have any scheduling preferences? _____
Morning, Afternoon, Evening, Weekends (circle)? M, Tu, W, Th, F, Sa? ONLY?
Communications preferences (circle)? Email, Text, Home Phone, Cell Phone, Written, Language
Personnel Requests? _____
Do you require any special needs while receiving care here? _____
Ex. wheelchair access, no stairs, blanket, no music, headphones