Affleck Dental
Restoration & Prosthodontics
Michael S. Affleck, D.D.S.

466 N. Main, Suite 100
Clearfield, UT 84015

(801) 782-5010

HEALTH HISTORY

(Please Print)

Name _____ Age _____ Date of Birth _____

DENTAL

1. Name of referring dentist or person _____

2. Are you having pain or discomfort at this time? ..... ❑ Yes ❑ No

3. Do you have any present dental complaints (bleeding gums, loose teeth, unhappy with appearance, etc.)? ❑ Yes ❑ No

If so, explain _____

4. Have you ever had an unusual reaction to dental anesthetic? ..... ❑ Yes ❑ No

5. If you have or ever have had the following, check the box:

- ❑ Cold or Canker sores
- ❑ Sensitivity to biting or pressure
- ❑ Sensitivity to hot, cold or sweets
- ❑ Food trapped between teeth
- ❑ Pain, clicking, or popping of jaw
- ❑ Frequent headaches
- ❑ Injury to face, jaw or teeth
- ❑ Clenching or grinding teeth
- ❑ Periodontal (gum) treatment
- ❑ Orthodontic treatment (braces)
- ❑ Chronic Snoring
- ❑ Frequent day time sleepiness

6. If you or your family are interested in any of our additional services please check box:

- ❑ Cosmetic Dentistry
- ❑ Implant's
- ❑ Crown/Bridge/Veneers
- ❑ Dentures
- ❑ Whitening
- ❑ Cleanings

7. Any other dental condition not mentioned above: _____

8. Are you interested in, or have you considered, makeover procedures like cosmetic dentistry or plastic surgery? ❑ Yes ❑ No

MEDICAL

1. The name, address and phone number of my physician is _____

2. Are you currently under the active care of a physician for a specific condition? ..... ❑ Yes ❑ No

If so, what is the condition? .....

3. Has there been any change in your general health within the past year? ..... ❑ Yes ❑ No

4. Have you had any serious illness within the past five (5) years? ..... ❑ Yes ❑ No

If so, what was/is the illness? .....

5. Have you been hospitalized or had an operation within the past five (5) years? ..... ❑ Yes ❑ No

If so, what was the reason? .....

6. Do you have or have you ever had any of the following diseases or problems:

a. Rheumatic Fever or Rheumatic Heart Disease ..... ❑ Yes ❑ No

b. Heart Disease (Artificial Heart Valves, Endocarditis, Congenital heart malformations, Mitral valve prolapse with valvular regurgitation, cardiomyopathy) ..... ❑ Yes ❑ No

c. Cardiovascular Disease (Heart Attack, Coronary Insufficiency, Coronary Occlusion, High Blood Pressure, Arteriosclerosis, Stroke, etc.) ..... ❑ Yes ❑ No

d. Hepatitis (any type) ..... ❑ Yes ❑ No

e. Jaundice, Cirrhosis or Liver Disease ..... ❑ Yes ❑ No

f. Tuberculosis, Bronchitis or Emphysema ..... ❑ Yes ❑ No

g. Sinus Trouble, Asthma or Hayfever ..... ❑ Yes ❑ No

(please continue on other side)

7. (continued) Do you have or have you ever had any of the following diseases or problems:

h. Severe Headaches, Earaches or Loss of Hearing Hives or Skin Rash ❑ Yes ❑ No
j. Fainting Spells, Seizures or Convulsions ❑ Yes ❑ No
k. Diabetes ❑ Yes ❑ No
l. Arthritis or Inflammatory Rheumatism ❑ Yes ❑ No
m. Artificial or Prosthetic Joint Replacement ❑ Yes ❑ No
n. Ulcers, Gastritis, Colitis or other Stomach or Intestinal Conditions ❑ Yes ❑ No
o. Kidney or Bladder Troubles ❑ Yes ❑ No
p. Organ Transplant (kidney, heart, etc.) ❑ Yes ❑ No
q. Immune System Disorders (AIDS, HIV, or ARC) ❑ Yes ❑ No
r. Sexually Transmitted Disease (Venereal Disease) ❑ Yes ❑ No
s. Glaucoma, Cataracts ❑ Yes ❑ No
t. Other ❑ Yes ❑ No

8. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? ❑ Yes ❑ No

9. Do you have any blood disorder such as anemia, leukemia or sickle cell anemia? ❑ Yes ❑ No

10. Have you had surgery or radiation treatment for a tumor, growth or other condition? ❑ Yes ❑ No

11. List any medications (prescription and over-the-counter, such as aspirin or vitamins) that you are now taking or have taken within the past 6 months. Include everything: Antibiotics, Anticoagulants (Blood Thinners), High Blood Pressure Medicine, Cortisone (Steroids), Tranquilizers or Antidepressants, Antihistamines, Insulin or other Diabetic Medications, Digitalis or other Heart Medications, Nitroglycerine, etc.:

_____

_____

12. Are you allergic to or have you ever reacted adversely to any medications? ❑ Yes ❑ No

If so, list them: _____

13. Do you use or have you used street drugs? ❑ Yes ❑ No

14. Do you use tobacco in any form? ❑ Yes ❑ No

15. Do you use any alcohol products? ❑ Yes ❑ No

16. Are you engaged in any situation which exposes you to x-rays or other ionizing radiation? ❑ Yes ❑ No

17. Women - Are you pregnant or do you have any reason to think you may be pregnant? ❑ Yes ❑ No

18. Women - Are you taking birth control pills or hormone therapy? ❑ Yes ❑ No

19. Do you have any disease, condition or problem not listed above? ❑ Yes ❑ No

If so, explain _____

HEALTH QUESTIONNAIRE ACKNOWLEDGMENT: I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medication can affect dental treatment, I understand the importance of and agree to notify he dentist of any changes at any subsequent appointment.

Signature _____ Date _____

HEALTH HISTORY UPDATES

Date _____ Change(s) ❑Yes ❑No _____

Date _____ Change(s) ❑Yes ❑No _____

Date _____ Change(s) ❑Yes ❑No _____

Date _____ Change(s) ❑Yes ❑No _____

Date _____ Change(s) ❑Yes ❑No _____

Date _____ Change(s) ❑Yes ❑No _____

Date _____ Change(s) ❑Yes ❑No _____