Amy D. Russell, DMD
1651 Mt. Vernon Rd.
Dunwoody, GA 30338

HEALTH HISTORY

Correct answers to the following questions will allow us to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name:_____Birthdate:_____

Why are you seeking dental treatment? _____

Please answer each question. Circle yes or no. If in doubt, leave blank.

1. Are you in good health? _____
Yes No
2. Previous Dentist and contact information_____
3. Are you under the care of a physician? _____
Yes No
If so, what is the condition being treated? _____
4.Have you ever been hospitalized or had a serious illness? _____
Yes No
If yes, explain: _____
5. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously?_____
Yes No
6. (Women) Are you pregnant? If so, give due date:_____
Yes No
7. Do you use tobacco in any form? If yes, how much?_____
Yes No
8. Do you use alcoholic beverages (more than 2 drinks per day)?_____
Yes No
9. Have you ever been told to pre-medicate prior to dental work?_____
Yes No
10. Do you have or have you ever had any of the following?

GENERAL HEART/BLOOD VESSELS
Tire easily, weakness Yes No
Marked weight change Yes No
Night sweats Yes No
Persistent fever Yes No

SKIN
Eruptions (rash) hives Yes No
Change in skin color Yes No

EYES
Visual Change Yes No
Glaucoma Yes No

EARS
Changes in hearing Yes No

NOSE
Frequent nosebleeds Yes No
Sinus problems Yes No

THROAT
Soreness/hoarseness Yes No

NERVOUS SYSTEM
Stroke Yes No
Headaches Yes No
Convulsions/epilepsy Yes No
Dizziness/fainting Yes No
Psychiatric treatment Yes No

RESPIRATORY
Tuberculosis Yes No
Emphysema Yes No
Asthma/hay fever Yes No
Persistent cough Yes No
Sputum production (Phlegm) Yes No
Cough up bloody sputum Yes No
Difficulty breathing lying down Yes No

ENDOCRINE
Thyroid condition/goiter Yes No
Diabetes (Including gestational) Yes No

HEART BLOOD VESSELS
Rheumatic Fever Yes No
Heart Murmur Yes No
Chest pain/discomfort Yes No
Heart attack/trouble Yes No
Shortness of breath Yes No
High blood pressure Yes No
Congenital heart disease Yes No
Artificial heart valve Yes No
Pacemaker Yes No
Heart surgery Yes No
Other _____ Yes No

BONE/MUSCLES
Arthritis/rheumatism Yes No
Artificial joints Yes No

DIGESTIVE SYSTEM
Hepatitis Yes No
Jaundice Yes No
Ulcers Yes No

URINARY
Kidney disease Yes No
Increase in frequency of urination (night) Yes No

BLOOD
Anemia Yes No
Bruise easily Yes No
Blood transfusion Yes No

OTHER
Radiation therapy Yes No
Cancer Yes No
Tumors or growths Yes No
AIDS Yes No

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11. Are you ALLERGIC or have you ever experienced any reaction to the following?
Local anesthetics (e.g. Novocain) Yes No Aspirin or codeine Yes No

Sulfa drugs	Yes No	Penicillin/other antibiotics	Yes No
Barbiturates/sedatives/sleeping pills	Yes No	Other allergies _____	

12. Are you taking any of the following?

Antibiotics/sulfa drugs	Yes No	Cortisone/steroids	Yes No
Tranquillizers	Yes No	Digitalis/other heart medications	Yes No
Blood thinners	Yes No	Nitroglycerin	Yes No
Insulin/other diabetes drugs	Yes No	Aspirin	Yes No
Blood pressure medication	Yes No	Antihistamines/allergy /cold medications	Yes No
Recreational drugs	Yes No	Other	
Thyroid medication	Yes No	medication_____	

If yes to any of the above, list name of medication and dosage below:
_____
_____
_____
13. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain: _____
14. Physician's Name: _____ Phone: _____
15. Have you ever had any serious trouble associated with previous dental treatment? Yes No
If so, explain:_____
16. Date of last dental visit:_____Date of last x-rays:_____
17. Does dental treatment make you nervous? Yes No Mild Moderate Severe
18. Have you ever been treated for periodontal disease(gum disease, pyorrhea, trench mouth)? Yes No
19. Do you have or have you ever had any of the following?

MOUTH TEETH		Clicking/popping jaw	Yes No
Bleeding, sore gums	Yes No	Shifting of teeth	Yes No
Loose teeth	Yes No	Difficulty opening or closing jaw	Yes No
Unpleasant taste/bad breath	Yes No	Change in bite	Yes No
Sensitive to hot	Yes No	**ORAL HYGIENE**	
Burning tongue/lips	Yes No	Do you use the following? How often do you use the following?	
Sensitive to cold	Yes No		
Frequent blister, lips/mouth	Yes No	Toothbrush	Yes No
Sensitive to sweets	Yes No	_____ Day Week Month Year	
Swelling/lumps in mouth	Yes No	Dental floss	Yes No
Sensitive to biting	Yes No	_____ Day Week Month Year	
Ortho treatments (braces)	Yes No	Fluoride rinse	Yes No
Food impaction	Yes No	_____ Day Week Month Year	
Biting cheeks/lips	Yes No	Toothbrush is:	soft medium hard
Clenching/grinding	Yes No		

I consent and authorize Amy Russell, DMD to use my photographs, video, slides, or any other image as may be necessary of me, with or without my given name, or with a fictitious name for advertising, education, or any other lawful purpose and I release and forever discharge them from any claim, demands, or liability on account of such use or for the quality of the reproduction of the photograph or photocopy provided.
To the best of my knowledge, all of the preceding answers are true and correct.
If I ever have any change in my health or change in my medication, I will inform the dentist at my next dental appointment.
Signature of patient, parent or guardian:_____Date:_____