Health History

We would like to welcome you to our office and thank you for choosing us as your oral health care provider. We the staff of Sabre Springs Dentistry are committed to exceeding the expectation of our clients every day. In order to address your oral health care needs safely and efficiently we need information about your general and oral health. We appreciate your cooperation in providing us with accurate information. If you have any questions we will be glad to help you.

(if you do not see the fill out fields (sky blue background) please click on "Highlight Fields"tab at the top right hand corner of this page)

Patient Name: ______ **Date of Birth:** ______ **Date:** ______

Are you currently under the care of a physician? Yes No if yes what is it for? ______

Date of last visit to your Physician: ______ Physician's name ______ Phone # ______

Are you taking any medication(s) including over the counter? Yes No if yes, please list the Name, Dose and Frequency of your medication(s) (please use **separate** sheet if needed)

______

Have you had any serious illness or operation in the last five years? Yes No if yes, please describe:

______

Are you aware of having or have you ever had an allergic reaction to any of the following? if yes please check:

Aspirin Codeine Dental Anesthesia Latex Metals Penicillin Sulfa **Erythromycin** Others None

Please check "Yes" or "No" if you have or you had any of the following conditions:

Condition	Yes	No	Condition	Yes	No	Comments (office use only)
Abnormal Bleeding			**Heart murmur**			
Alcohol Abuse			**Heart surgery**			
Anemia			Hemophilia			
Angina pectoris/chest pain			**Hepatitis B**			
Arthritis			**Hepatitis C**			
Artificial heart valve			**High Blood Pressure**			
Asthma			Joint Replacement			
Back/neck pain			Jaundice			
Blood transfusion			Kidney/bladder disease			
Cancer			Liver disease			
Chemotherapy			Migraine			
Colitis			**Mitral valve prolapse**			
Congenital heart defect			Pacemaker/defibrillator			
Coronary angioplasty			Osteoporosis			
Coronary bypass			Osteoarthritis			
Diabetes			Psychiatric problems			
Difficulty breathing			Radiation therapy			
Drug abuse			Rheumatic fever			
Emphysema			Sexually Transmitted Disease			
Epilepsy/Seizure			Sickle cell anemia			
Fainting spells			Sinus problems			
Frequent headache			Stroke			
Glaucoma			Thyroid problems			
HIV+/AIDS			Tuberculosis			
Heart attack			Ulcer			

Do you have or had any other condition(s) not listed above? Yes No if yes please describe: ______ over...

Health History (cont...)

Have you ever taken any of the drugs collectively referred to as: fen-Phen"? These include combinations of Lonimin, Adipex, Fastin, Pondimin and Redux ? Yes No

Have you ever taken any Bisphosphonate medications including Fosamax, Actonel, Boniva, Skelid, Didronel, **Aredia,** Zoemta, and Bonefos ? Yes "No if Yes, was it for:

Multiple Myeloma Metastatic cancer **Paget's Disease** Osteoporosis

How long you have been taking the bisphosphonate? __________

Did/Do you smoke? Yes No If Yes, How long have you been smoking? __________ How many packs/day? ______

Did/Do you chew **tobacco?** Yes No If Yes, For how long ? __________ How many/day __________

Did/Do you drink alcohol? Yes No If Yes, How often? __________ How much? __________

Women only:

Are you Pregnant? Yes No Maybe Are you Nursing? Yes No

Are you taking birth control pills? Yes No Menopause? Yes No

ORAL HEALTH HISTORY

Why have you come to the dentist today? ____________________

Date of your last dental check-up? __________ Date of your last Dental X-rays __________

Your Previous Dentist name: __________ Address: __________ Phone #: __________

Why did you leave your previous dentist? ____________________

Are you happy with your smile? Yes No If No, Why? ____________________

Do you have or had any braces in the past? Yes No If Yes, for how long? __________

Have you had any history of periodontal disease? Yes No If Yes How long ago? __________

Has fear or anxiety been an issue for you in any dental office? Yes No If Yes, please explain: __________

Please check on "Yes" or "No" if you have or have had any of the following conditions:

Condition	Yes	No	Condition	Yes	No	Comments (office use only)
Abscess			Pain around ears			
Bleeding gum			Clicking/popping/locking jaw			
Loose teeth			Grinding teeth			
Swollen gum			Pain in jaw/face/neck			
Discolored teeth			Surgery in the jaw			
Dry mouth			Burning sensation in mouth			
Bad breath			Sensitivity to cold			

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by Dr. Habibian and her staff to help determine appropriate dental treatment. If there are any changes in my medical status, I will always inform Dr. Habibian and her staff. Please sign and date below:

Name (Patient/ Parent/ Guardian): ____________________ **Date:** ____________________

Signature (Patient/Parent/ Guardian): ____________________

Dentist Signature ____________________ **Date** ____________________

Please bring the complete form when you come for your appointment.
Thank you for your cooperation