Blake Nelson DDS
Cosmetic, Implant and Sedation Dentistry
3066 Trenwest Dr. Winston-Salem, NC 27103
(336)760-1277

Health History Form

Name: _____ **Date of birth** _____

Today's Date: _____

MEDICAL HISTORY

1. Name of physician(s): _____
2. Are you currently taking any medications, pills, or drugs?
   Yes No
   - If yes, please list: _____
3. Do you have any allergies (latex, penicillin, sulfa drugs, dental anesthetic, etc.)?
   Yes No
   - If yes, please list: _____
4. Do you currently smoke or drink alcohol?
   Yes No
   - If yes, how much? Smoke: _____ packs per day Drink: _____ drinks per week
5. Have you ever taken bisphosphonates/medicines or injection for weak bones/osteoporosis (Actonel, Boniva, Fosamax, Reclast, Zometa, etc.)? Yes No
   - If yes, please explain: _____
6. Do you currently or have you ever had any of the following (circle all that apply)?

● Heart Disease	Yes	No	● Artificial Joints	Yes	No
● Heart Murmur	Yes	No	● Cancer or Tumors	Yes	No
● Mitral Valve Prolapse	Yes	No	● Radiation or Chemotherapy	Yes	No
● Rheumatic Fever	Yes	No	● Aids or HIV	Yes	No
● Stroke	Yes	No	● Sexually Transmitted Disease	Yes	No
● High Blood Pressure	Yes	No	● Hepatitis or Liver Disease	Yes	No
● Asthma	Yes	No	● Kidney Disease	Yes	No
● Blood Disease	Yes	No	● Stomach or Intestinal Issues	Yes	No
● Excessive Bleeding	Yes	No	● Tuberculosis	Yes	No
● Diabetes	Yes	No	● Major Operation or Illness	Yes	No
● Epilepsy or Seizures	Yes	No	● Females: Are you pregnant?	Yes	No
● Fainting spells	Yes	No	● Females: Are you nursing?	Yes	No
● Arthritis	Yes	No			

If yes to any of the above, please explain:

_____

_____

7. Please list and surgeries you have undergone and the dates (approximate dates are fine for procedures a long time ago):

(1) _____

(2) _____

(3) _____

(4) _____

(5) _____

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Medical History Form

(6) _____

DENTAL HISTORY

1. What dental problem/concern brought you in today?
   _____
2. Do you have any dental concerns, worries, or complaints?
   _____
3. How often do you brush and floss your teeth? Brush: _____ per day Floss: _____ per week
4. When was your last dental visit? _____ Have you recently had any dental x-rays?
   Yes No
5. Have you ever had any complications following dental treatment?
   Yes No
   - If yes, please explain:
     _____
6. Have you ever suffered an injury to your teeth, jaws, or face?
   Yes No
   - If yes, please explain:
     _____
7. Are you happy with the appearance of your teeth and smile?
   Yes No
   - If no, please explain:
     _____
8. Do you grind your teeth?
   Yes No
9. Do you experience jaw pain?
   Yes No

I understand the need for these questions to be answered truthfully and to the best of my knowledge. I also understand it is very important to report any change in my medical or dental status to the dentist at the earliest possible time and I agree to do so.

Signature of person completing this form: _____Date_____

If other than patient, relationship _____