# LESLIE G. PLATOCK, D.D.S.

COSMETIC AND GENERAL DENTISTRY

## Health History

Patient Name______________________________ Social Security #____________________________DOB ________________

Address___________________________________City_________________State___________Zip_________________________

Home Phone _(_____)________________________Work #_________________________Cell ___________________________

Email _________________________________________________Employer __________________________________________

*Please check all that apply:*

- ❒ Bad Breath
- ❒ Bleeding gums
- ❒ Blisters on lips or mouth
- ❒ Burning sensation on tongue
- ❒ Cigarette/tobacco
- ❒ Clicking or popping jaw
- ❒ Dry mouth
- ❒ Food collection between teeth
- ❒ Grinding teeth
- ❒ Loose teeth or broken fillings
- ❒ Periodontal treatment
- ❒ Sensitivity to cold/hot/sweets
- ❒ Sensitivity when biting
- ❒ Do you snore?
- ❒ Mouth Ulcers

**Medical History**

Physician's Name________________________________ City/Phone______________________ Date of last visit_____________

Do you have chronic headaches or migraines? ❒**Yes** ❒ **No** Do you take aspirin? ❒**Yes** ❒ **No** Are you pregnant? ❒**Yes** ❒ **No** Do you take birth control pills? ❒**Yes** ❒ **No** Have you ever had orthodontic treatment**?** ❒**Yes** ❒ **No** How often do you brush?________ Floss?________ Do you wear a sleep device? ❒**Yes** ❒ **No** **D**o you wear a mouth-guard? ❒**Yes** ❒ **No**

List prior serious illnesses or operations___________ _______________________________________________________________

Have you ever been told you need to take pre-meds before a dental treatment**?** ❒**Yes** ❒ **No**

*Please check all that apply:*

- ❒ Anemia
- ❒ Arthritis, Rheumatism
- ❒ Artificial Heart Valves ?Stents
- ❒ Artificial joints
- ❒ Asthma, use of inhaler ❒Yes ❒ No
- ❒ Back Problems
- ❒ Blood disease
- ❒ Cancer
- ❒ Chemical Dependency
- ❒ Chemotherapy, date:________
- ❒ Circulatory Problems
- ❒ Cortisone Treatments
- ❒ Cough, persistent/bloody
- ❒ Diabetes
- ❒ Dizziness
- ❒ Epilepsy
- ❒ Fainting
- ❒ Glaucoma
- ❒ Headaches
- ❒ Heart Murmur
- ❒ Heart Problems
- ❒ Hemophilia
- ❒ High Blood Pressure
- ❒ HIV/AIDS
- ❒ Jaw Pain
- ❒ Kidney Disease
- ❒ Liver Disease
- ❒ Low Blood Pressure
- ❒ Hepatitis A__, B___, C___
- ❒ Mitral Value Prolapse
- ❒ Pacemaker
- ❒ Radiation Treatment, date____
- ❒ Respiratory Disease
- ❒ Rheumatic Fever
- ❒ Scarlet Fever
- ❒ Shortness of Breath
- ❒ Skin Rash
- ❒ Stroke
- ❒ Swelling of Feet/Ankles
- ❒ Thyroid Problems
- ❒ Tonsillitis
- ❒ Tuberculosis
- ❒ Stomach Ulcer

**List any medications you are currently taking:** _____________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

**Allergies**

- ❒ Aspirin
- ❒ Barbiturates (sleeping pills)
- ❒ Codeine
- ❒ Local Anesthetics
- ❒ Erythromycin
- ❒ Latex
- ❒ Penicillin
- ❒ Sulfa
- ❒ Tetracycline
- ❒ Other : ______________

To cancel or reschedule an appointment, the office must be given a 24 hour notice in order to avoid being charged a **$75.00** fee. _____Initialed

Dated: _________________ Signature____________________________________ Print Name_____________________________

Dr. Initialed_______________