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Patient Health History

Patient Name _____ DOB _____

Welcome to our office. Please fill out this Health History form so we may be aware of any medical conditions you may have or have had. Use the Additional Comments at the end of the form to include any extra information. Thank you.

Please circle Yes or No or fill in where appropriate.

Name of your physician _____

Physician's Phone # _____ Date of last visit _____

Primary reason for this appointment. _____

Yes No Are you apprehensive about dental treatment?

Yes No Have you had a previous problem with dental care?

Yes No Do you gag easily?

Yes No Do you wear dentures?

Yes No Does food catch between your teeth?

Yes No Do you have difficulty chewing?

Yes No Do your gums bleed when you floss?

Yes No Do your gums feel swollen and/or tender?

Yes No Do you get sores in or around your mouth?

Yes No Are your teeth sensitive?

To what? _____

Yes No Do you take fluoride supplements?

My primary drinking water is is not fluoridated.

Yes No Do you feel your teeth could look nicer?

Yes No Do your jaws click or pop?

Yes No Are you aware of clenching or grinding your teeth?

Yes No Do your jaws ever feel 'tired'?

Yes No Does your jaw ever get stuck open?

Yes No Do you suffer from earaches?

Yes No Do you have headaches, earaches or jaw pain when you awake?

Yes No Do you take medication for pain or discomfort?

Yes No Do you have a TMJ (temporomandibular joint) disorder?

Yes No Are you able to open your mouth fully?

Yes No Are you aware of an uncomfortable bite?

Yes No Have you ever suffered a jaw injury?

Yes No Are you a habitual gum chewer?

Yes No Do you wear a night guard?

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Medical History

- Yes No Heart problems?
- Yes No Chest pain?
- Yes No Shortness of breath?
- Yes No High blood pressure?
- Yes No Low blood pressure?
- Yes No Heart murmur?
- Yes No Heart valve problem or repair?
- Yes No Take heart medication?
- Yes No Rheumatic fever?
- Yes No Pacemaker?
- Yes No Artificial heart valve?
- Yes No Blood problems?
- Yes No Easily bruise?
- Yes No Frequent nosebleeds?
- Yes No Anemic?
- Yes No Ever had a blood transfusion?
- Yes No Allergies?
- Yes No Hay fever?
- Yes No Sinus problems?
- Yes No Skin rashes?
- Yes No Take allergy medication?
- Yes No Asthma?
- Yes No Intestinal problems?
- Yes No Ulcers?
- Yes No Unusual weight gain or loss?
- Yes No Special diet?
- Yes No Constipation/diarrhea?
- Yes No Kidney or bladder problems?
- Yes No Bone or joint problems?
- Yes No Arthritis?
- Yes No Back or neck pain?
- Yes No Joint, hip or knee replacement or surgery?
- Yes No Fainting spells, seizures or epilepsy?
- Yes No Frequent or severe headaches?
- Yes No Thyroid problems?
- Yes No Diabetes?
- Yes No Urinate more than 6 times a day?
- Yes No Thirsty or have dry mouth much of the time?
- Yes No Family history of diabetes?
- Yes No Tuberculosis or other respiratory disease?
- Yes No Cancer/Tumor?
- Yes No Do you drink alcohol?

How much? _____

- Yes No Do you smoke?

How much? _____

- Yes No Hepatitis, jaundice or liver problems?
- Yes No Herpes or other sexually transmitted diseases?
- Yes No HIV-Positive or AIDS?
- Yes No Glaucoma?
- Yes No History of head injury or concussion?
- Yes No Epilepsy or other neurological disease?

Yes No History of alcohol or drug abuse?
Yes No Are you allergic to any medications or anesthetics?
Which ones? _____

Yes No Have you ever used the diet drug Phen-fen?
What medications are you currently taking?

You may attach a list if that is more convenient.

Yes No Do you need antibiotics before any dental treatment (heart problems,
joint replacements)
Doctor's name who prescribed or indicated you needed them?

What other medications have you taken in the last 12 months?

Yes No Have you had any serious illnesses, operations or hospitalizations
within the last 5 years?

Women

Yes No Are you taking contraceptives or other hormones?
Yes No Are you pregnant?
Yes No Are you nursing?
Yes No Have you reached menopause?
ADDITIONAL COMMENTS? Anything else you think we should know?

I certify that I have read, understood and answered the above questions correctly and that
misinformation can have serious health consequences. I will not hold my dentist nor any
member of his staff responsible for any errors or omissions in this form.

Signature _____ Date: _____

Reviewed by	Comment	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____