Health History Form

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: Last, First, Middle Home Phone: ( ) Business: ( ) Cell: ( )

Mailing Address: City: State: Zip Code:

Occupation: Height: Weight: DOB: Sex: M F

SS#: Emergency Contact: Relationship: Home Phone: ( ) Cell: ( )

If you are completing this form for another person, what is your relationship to that person?

Name: Relationship:

Do you have any of the following: Active tuberculosis, persistent cough (greater than a 3 week duration), cough that produces blood, or have you been exposed to anyone with tuberculosis? **If you answer yes to any of the items above, please stop and return this form to the receptionist.**

Dental Information: Please mark (X) your responses to the following questions (Check DK if you don't know the answer to the questions)

	Yes	No	DK		Yes	No	DK
Do you participate in active recreational activities?	☐	☐	☐	Do your gums bleed when you brush/floss?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐	Is your mouth dry?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐	Do you wear dentures or partials?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐	Do you have earaches or neck pains?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets, or pressure?	☐	☐	☐	Do you have sores or ulcers in your mouth	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐	Do you brux or grind your teeth?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐	Have you ever had braces (orthodontic treatment)?	☐	☐	☐
Are you currently experiencing dental pain or discomfort?	☐	☐	☐	Is your home water supply fluoridated?	☐	☐	☐

What is the reason for your visit today? How do you feel about your smile?

Medical Information:

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician's Name: Phone: ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the last year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem:

Are you taking or have you recently taken any prescription or over the counter medicines? Yes ☐ No ☐ DK ☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Allergies: Are you allergic to or have you had a reaction to: To all YES responses, specify type of reaction

	Yes	No	DK		Yes	No	DK		Yes	No	DK
Local Anesthetics_____	☐	☐	☐	Penicillin/other antibiotic_____	☐	☐	☐	Metals_____	☐	☐	☐
Hay Fever/Seasonal_____	☐	☐	☐	Barbiturates/Sedatives/Sleeping pills____	☐	☐	☐	Food_____	☐	☐	☐
Sulfa Drugs_____	☐	☐	☐	Codeine or other Narcotics_____	☐	☐	☐	Latex (rubber)_____	☐	☐	☐
Animals_____	☐	☐	☐	Aspirin_____	☐	☐	☐	Iodine_____	☐	☐	☐

Other_____

For Office Use Only:

Do you wear contact lenses?..... Yes ☐ No ☐ DK ☐

Joint Replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?..... Yes ☐ No ☐ DK ☐

Date:_____ Have you had any complications?_____

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risendronate (Actonel) for osteoporosis or Paget's disease?..... Yes ☐ No ☐ DK ☐

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?..... Yes ☐ No ☐ DK ☐

Date treatment began:_____

WOMEN ONLY Are you:

Pregnant?..... Yes ☐ No ☐ DK ☐

Number of weeks:_____

Nursing?..... Yes ☐ No ☐ DK ☐

Taking birth control pills or hormonal replacement?.. Yes ☐ No ☐ DK ☐

Mark your response to indicate if you have/have not had any of the following:

	Yes	No	DK
Artificial (prosthetic) heart valve?.....	☐	☐	☐
Previous infective endocarditis?.....	☐	☐	☐
Damaged valves in transplanted heart?.....	☐	☐	☐
Congenital heart disease (CHD)?.....	☐	☐	☐
Unrepaired, cyanotic CHD?.....	☐	☐	☐
Repaired (completely) in last 6 months?...	☐	☐	☐
Repaired CHD with residual defects?.....	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease...	☐	☐	☐
Angina.....	☐	☐	☐
Arteriosclerosis.....	☐	☐	☐
Congestive heart failure..	☐	☐	☐
Damaged heart valves....	☐	☐	☐
Heart attack.....	☐	☐	☐
Heart murmur.....	☐	☐	☐
Low blood pressure.....	☐	☐	☐
High blood pressure.....	☐	☐	☐
Other congenital heart defects.....	☐	☐	☐

	Yes	No	DK
Mitral valve prolapse.....	☐	☐	☐
Pacemaker.....	☐	☐	☐
Rheumatic fever.....	☐	☐	☐
Rheumatic heart disease.	☐	☐	☐
Abnormal bleeding.....	☐	☐	☐
Anemia.....	☐	☐	☐
Blood transfusion.....	☐	☐	☐
If yes, date: _____			
Hemophilia.....	☐	☐	☐
AIDS.....	☐	☐	☐
Arthritis.....	☐	☐	☐

	Yes	No	DK
Autoimmune disease.....	☐	☐	☐
Rheumatoid arthritis.....	☐	☐	☐
Lupus.....	☐	☐	☐
Asthma.....	☐	☐	☐
Bronchitis.....	☐	☐	☐
Emphysema.....	☐	☐	☐
Sinus trouble.....	☐	☐	☐
Tuberculosis.....	☐	☐	☐
Cancer/Chemotherapy Radiation Treatment.....	☐	☐	☐
Chest pain w/exertion....	☐	☐	☐
Chronic pain.....	☐	☐	☐
Diabetes Type I / Type II...	☐	☐	☐
Eating Disorder.....	☐	☐	☐
Malnutrition.....	☐	☐	☐
Gastrointestinal disease.	☐	☐	☐
G.E. Reflux/persistent heartburn.....	☐	☐	☐
Ulcers.....	☐	☐	☐
Thyroid problems.....	☐	☐	☐
Stroke.....	☐	☐	☐
Glaucoma.....	☐	☐	☐

	Yes	No	DK
Hepatitis, jaundice or liver disease.....	☐	☐	☐
Epilepsy.....	☐	☐	☐
Fainting spells/seizures.....	☐	☐	☐
Neurological disorders.....	☐	☐	☐
If yes, specify:_____			
Sleep disorder.....	☐	☐	☐
Mental health disorders.....	☐	☐	☐
Specify:_____			
Recurrent Infections.....	☐	☐	☐
Type of infection:_____			
Kidney problems.....	☐	☐	☐
Night sweats.....	☐	☐	☐
Osteoporosis.....	☐	☐	☐
Persistent swollen glands in neck.....	☐	☐	☐
Severe headaches/ migraines.....	☐	☐	☐
Severe or rapid weight loss....	☐	☐	☐
Sexually transmitted disease..	☐	☐	☐
Excessive urination.....	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?..... Yes ☐ No ☐ DK ☐

Name of physician or dentist making recommendation: Phone: ( )

Do you have any disease, condition, or problem not listed above that you think I should know about?..... ☐ ☐ ☐

Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date: