Health History Form

Patient Information

First Name	Middle Name	Last Name
-	-	-
Email	**Home Phone**	**Business/Cell Phone**
-	-	-
Address	**City**	**State**
-	-	-
ZIP Code	**Occupation**	**Height**
-	-	-
Weight	**Date of Birth**	**Gender**
-	-	-
SS# or Patient ID	**Emergency Contact**	**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.

Responsible Party

If you are filling out this form on behalf of another person, please mention your name and your relationship with that person

Your Name	Relationship
-	-

Medical Conditions

Do you have or have you had any of the following medical conditions?
Choose *Don't Know* if you don't know or not sure of the answer to any question

Active Tuberculosis	Persistent cough greater than a 3 week duration	Cough that produces blood
-	-	-

Been exposed to anyone with tuberculosis

-

If you answered YES to any of the 4 medical conditions listed above, please stop filling out this form and contact our office.

Dental Information

Do your gums bleed when you brush or floss?

-

Are your teeth sensitive to cold, hot, sweets or pressure?

-

Is your mouth dry?

-

Have you had any periodontal (gum) treatments?

-

Have you ever had orthodontic (braces) treatment?

-

Have you had any problems associated with previous dental treatment?

-

Is your home water supply fluoridated?

-

Do you drink bottled or filtered water?

-

If yes, how often do you drink bottled or filtered water?

-

Are you currently experiencing dental pain or discomfort?

-

Do you have earaches or neck pains?

-

Do you have any clicking, popping or discomfort in the jaw?

-

Do you brux or grind your teeth?

-

Do you have sores or ulcers in your mouth?

-

Do you wear dentures or partials?

-

Do you participate in active recreational activities?

-

Have you ever had a serious injury to your head or mouth?

-

Date of your last dental exam

-

What was done at that time?

-

Date of last dental x-rays

-

What is the reason for your dental visit today?

-

How do you feel about your smile?

-

Medical Information

Are you now under the care of a physician?

-

Physician Name

-

Phone

-

Address/City/State/Zip

-

Are you in good health?

-

Has there been any change in your general health within the past year?

-

If yes, what condition is being treated?

-

Date of last physical exam

-

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 medicine(s)?
-

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements
-

Do you wear contact lenses?
-

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?
-

Date
-

If yes, have you had any complications?
-

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax® , Actonel® , Atelvia, Boniva® , Reclast, Prolia) for osteoporosis or Paget's disease?
-

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia® , Zometa® , XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?
-

Date Treatment began
-

Do you use controlled substances (drugs)?
-

Do you use tobacco (smoking, snuff, chew, bidis)?
-

If so, how interested are you in stopping? Select one:
-

Do you drink alcoholic beverages?
-

If yes, how much alcohol did you drink in the last 24 hours?
-

If yes, how much do you typically drink in a week?
-

Allergies

Are you allergic to or have you had a reaction to?
If you answer YES to any of the following allergies, please specify their reaction, too.

Local anesthetics
-

-

Aspirin
-

-

Penicillin or other antibiotics
-

-

Barbiturates, sedatives, or sleeping pills
-

-

Sulfa drugs
-

-

Codeine or other narcotics
-

-

Metals
-

-

Latex (rubber)
-

-

Iodine
-

-

Hay fever/seasonal
-

-

Animals
-

-

Food
-

-

Other
-

FOR WOMEN ONLY

Are you pregnant?
-

Number of weeks
-

Taking birth control pills or hormonal replacement?
-

Are you nursing?
-

Please mark your response to indicate if you have or have not had any of the following diseases or problems

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

Cardiovascular disease
-

Angina
-

Arteriosclerosis
-

Congestive heart failure
-

Damaged heart valves
-

Heart attack
-

Heart murmur
-

Low blood pressure
-

High blood pressure
-

Other congenital heart defects
-

Mitral valve prolapse
-

Pacemaker
-

Rheumatic fever
-

Rheumatic heart disease
-

Abnormal bleeding
-

Anemia
-

Blood transfusion
-

If yes, please mention the date of blood transfusion
-

Hemophilia
-

AIDS or HIV infection
-

Arthritis
-

Autoimmune disease
-

Rheumatoid arthritis
-

Systemic lupus erythematosus
-

Asthma
-

Bronchitis
-

Emphysema
-

Sinus trouble
-

Tuberculosis
-

Cancer/Chemotherapy/ Radiation Treatment
-

Chest pain upon exertion
-

Chronic pain
-

Diabetes Type I or II
-

Eating disorder
-

Malnutrition
-

Gastrointestinal disease
-

G.E. Reflux/persistent heartburn
-

Ulcers
-

Thyroid problems
-

Stroke
-

Glaucoma
-

Hepatitis, jaundice or liver disease
-

Epilepsy
-

Fainting spells or seizures
-

Neurological disorders
-

If yes, specify
-

Sleep disorder
-

Do you snore?
-

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?
-

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?
-

NOTE: Both the 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 the Patient/Legal Guardian (ESign)

Date :

FOR OFFICE USE ONLY

Signature of the Dentist (ESign)	Date	Comments
Date :	-	-