

Health History Form

Name: _____ Home Phone: () _____ Cell Phone: () _____
LAST FIRST MIDDLE

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Business Phone: () _____ Spouse: _____ Your DOB: / / Sex: M F
CIRCLE ONE

SS# _____ Emergency Contact: _____ Relationship: _____ Phone() _____

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

For the following questions, please circle whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that you may be asked some questions about your responses and 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.

DENTAL INFORMATION

Do your gums bleed when you brush? Y N ?
 Have you ever had orthodontic (braces) treatment? Y N ?
 Are your teeth sensitive to cold/hot, sweets or pressure? Y N ?
 Do you have earaches or neck pains? Y N ?
 Have you had any periodontal (gum) treatments? Y N ?
 Do you wear removable dental appliances? Y N ?
 Have you had a serious/difficult problem associated with any previous dental treatment? Y N ?
 If yes, explain: _____

How would you describe your current dental problem? _____
 Date of your last dental exam? _____
 Date of your last dental x-rays: _____
 What was done at that time? _____
 How do you feel about the appearance of your teeth? _____

MEDICAL INFORMATION

If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.

Have you had any of the following diseases or problems?
 Active Tuberculosis Y N ?
 Persistent cough greater than a 3 week duration Y N ?
 Cough that produces blood Y N ?

Are you in good health? Y N ?
 Has there been any change in your general health in the past year? Y N ?
 Are you now under the care of a physician? Y N ?
 If yes, what is/are the condition(s) being treated? _____

Date of last physical examination: _____

Physician: _____
NAME PHONE

ADDRESS

Have you had any serious illness, operation, or been hospitalized in the past 5 years? Y N ?
 If yes, what was the illness or problem? _____

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Y N ?
 If yes, when was this operation done? _____
 Have you had any complications or difficulties with your prosthetic joint? _____
 Has a dentist or previous dentist recommended that you take antibiotics prior to your dental treatment? Y N ?
 If yes, what antibiotic and dose? _____

Name of Physician or dentist: _____
 Phone: () _____

Are you taking or have you taken any medicine(s) including non-prescription medicine? Y N ?
 If yes, what medicine(s) are you taking? _____

Prescribed: _____

Over the counter: _____

Vitamins, natural or herbal preparations and/or diet supplements: _____

Are you taking, or have you taken, any diet drugs such as:
 Pondimin (fenfluramine)
 Redux (dexphenfluramine)
 Or phen-fen (fenfluramine-phentermine combination)? Y N ?

Do you drink alcoholic beverages? Y N ?
 If yes, how much alcohol did you drink in the last 24 hours? _____
 In the past week? _____

Are you alcohol or drug dependent? Y N ?
 If yes, have you received treatment? Y N ?

Do you use drugs or substances for recreational purposes? Y N ?
 If yes, please list: _____
 Frequency of use (daily, weekly, etc): _____
 Number of years of recreational drug use: _____

Do you use tobacco (smoking, snuff, chew)? Y N ?
 If yes, how interested are you in stopping?
 Circle one Very / Somewhat / Not interested

Do you wear contact lenses? Y N ?

WOMEN ONLY

Are you or could you be pregnant? Y N ?
 Nursing? Y N ?
 Taking birth control pills or hormonal replacement? Y N ?

PLEASE COMPLETE BOTH SIDES

Are you allergic to or have you had a reaction to:

Local anesthetics Y N ?
 Aspirin Y N ?
 Penicillin or other antibiotics Y N ?
 Barbiturates, sedatives, or sleeping pills Y N ?
 Sulfa drugs Y N ?
 Codeine or other narcotics Y N ?
 Latex Y N ?
 Iodine Y N ?

Hay fever/seasonal Y N ?
 Animals Y N ?
 Food (specify) _____ Y N ?
 Other (specify) _____ Y N ?
 Metals (specify) _____ Y N ?
 To Yes responses, specify type of reaction. _____

Have you had any of the following diseases or problems?

Abnormal bleeding Y N ?
 AIDS or HIV infection Y N ?
 Anemia Y N ?
 Arthritis Y N ?
 Rheumatoid arthritis Y N ?
 Asthma Y N ?
 Blood transfusion. If yes, date: _____ Y N ?
 Cancer/Chemotherapy/Radiation Treatment Y N ?
 Cardiovascular disease. If yes, specify: Y N ?
 _____Angina _____Heart murmur
 _____Arteriosclerosis _____High blood pressure
 _____Artificial heart valves _____Low blood pressure
 _____Congenital heart defects _____Mitral valve prolapse
 _____Coronary artery disease _____Pacemaker
 _____Damaged heart valves _____Rheumatic heart disease
 _____Heart attack _____/Rheumatic fever
 Chest pain upon exertion Y N ?
 Chronic pain Y N ?
 Disease, drug, or radiation-induced
 Immunosuppression Y N ?
 Diabetes, If yes, specify below: Y N ?
 _____Type I (Insulin dependent) _____Type II
 Dry mouth Y N ?
 Eating disorder. If yes, specify _____ Y N ?
 Epilepsy Y N ?
 Fainting spells or seizures Y N ?
 Gastrointestinal disease Y N ?
 G.E. Reflux/persistent heartburn Y N ?
 Glaucoma Y N ?
 Hemophilia Y N ?
 Hepatitis, jaundice or liver disease Y N ?

Recurrent infections. If yes, type _____ Y N ?
 Kidney problems Y N ?
 Mental health disorders. Y N ?
 If yes specify: _____
 Malnutrition Y N ?
 Night sweats Y N ?
 Neurological disorders. Y N ?
 If yes, specify: _____
 Osteoporosis Y N ?
 Persistent swollen glands in neck Y N ?
 Respiratory problems. If yes, specify: Y N ?
 _____Emphysema _____Bronchitis, etc.
 Severe headaches/migraines Y N ?
 Severe or rapid weight loss Y N ?
 Sexually transmitted disease Y N ?
 Sinus trouble Y N ?
 Sleep disorder Y N ?
 Sores or ulcers in the mouth Y N ?
 Stroke Y N ?
 Systemic lupus erythematus Y N ?
 Tuberculosis Y N ?
 Thyroid problems Y N ?
 Ulcers Y N ?
 Excessive urination Y N ?

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

Please explain: _____

Whom may we thank for referring you to our office? _____

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. 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 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.

X
 SIGNATURE OF PATIENT/LEGAL GUARDIAN

DATE