

Health History Form

Name: _____ Home Phone _____ Business Phone _____
Last First Middle

Address _____ City _____ State _____ Zip Code _____
PO Box or Mailing address

Occupation _____ Height _____ Weight _____ Date of Birth ____/____/____ Sex M F

Emergency Contact _____ Relationship _____ Phone _____

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

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your visit 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.

Dental Information

Yes No Don't Know <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Do your gums bleed when you brush? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Are your teeth sensitive to cold, hot, sweets or pressure? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Have you had any periodontal (gum) treatments? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Have you had a serious/difficult problem associated with any previous dental treatment? If so, explain _____	Yes No Don't Know <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Have you ever had orthodontic (braces) treatment? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Do you have headaches, earaches or neck pain? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Do you wear removable dental appliances? _____
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

How would you describe your current dental problem? _____

Date of your last dental exam? _____ Date of last x-rays _____

What was done at that time? _____

How do you feel about the appearance of your teeth? _____

Medical Information

Yes No Don't Know

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

Do you have any of the following diseases or problems? **If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.**

Active Tuberculosis
 Persistent cough greater than a 3 week duration
 Cough that produces blood
 Are you now under the care of a physician? If so, what is/are the condition(s) being treated? _____
 _____ Date of last physical exam _____
 Physicians(s) _____

Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, what medicine(s) are you taking?
 Prescribed _____
 Over the counter _____
 Natural or herbal preparations _____

Are you taking, or have you taken, any diet drugs such as Pondimin (fendluramine), Redux (dexphenfuramine) or phen-fen(phentermine)?
 Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the last 24 hours _____ In the past month? _____
 If yes, _____ # of drinks per day for _____ # years

Are you alcohol and/or drug dependent? If so, have you received treatment? (Check one) YES NO
 Do you use drugs or other substances for recreational purposes? If yes, please list _____
 Frequency of use (daily, weekly, etc) _____ Number of years of recreational drug use _____

Do you use tobacco (smoking, snuff, chew)? If so, how interested are you in stopping? (Check one) Very Somewhat Not interested
 Do you wear contact lenses?

Allergies Are you allergic to or have you had a reactions to: (Please fill out both columns)

Yes No Don't Know <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Local anesthetics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Aspirin <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Penicillin or other antibiotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Barbiturates, sedatives or sleeping pills <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sulfa drugs <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Codeine or other narcotics	Yes No Don't Know <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Latex <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Iodine <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hay Fever/seasonal <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Animals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Food (specify) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other (Specify)
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

To yes responses, specify type of reaction _____

Please complete both sides

Yes No Don't Know

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If so when was this operation done? _____

Have you had any complications or difficulties with your prosthetic joint?

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? If so, what antibiotic and dose?
Name of physician or dentists _____ Phone _____

(Women Only)

Are you pregnant?

Nursing?

Taking birth control pills?

Please (X) if you have or had any of the following diseases

Yes	No	Don't know		Yes	No	Don't Know		Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Disease, drug or radiation induced immunosuppression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes, If yes specify below	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, specify _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	○ Type I	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	○ Type II	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent swollen glands in neck
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, specify below
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	○ Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes date _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	○ Bronchitis, etc
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Chemotherapy/radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells or seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe headaches
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardio vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GE reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe or rapid weight loss
			If yes, specify below	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease
			○ Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble
			○ Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice or liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder
			○ Artificial heart valves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sores or ulcers in the mouth
			○ Coronary insufficiency				indicate type of infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
			○ Coronary occlusion				_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus erythematosus
			○ Damaged heart valves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems
			○ Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
			○ Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
			○ High Blood pressure				If yes, specify below	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination
			○ Inborn heart defects				_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any disease
			○ Pacemaker				_____				condition or problem not listed
			○ Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition				above that you think I should
			○ Rheumatic heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraines				know about? Please explain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain upon exertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats				_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Pain								_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent diarrhea								_____

NOTE: Both doctor and patients 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 inquires 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 error or omission that I may have made in the completion of this form.

Signature of Parent/Legal Guardian _____

Date _____

For completion by dentist

Comments on patient interview concerning heath history _____

Significant findings from questionnaire or oral interview _____

Dental management considerations _____

Signature of Dentist _____

Date _____

Health History Update

Date **Comments**

Signature of patient or dentist

_____	_____	_____
_____	_____	_____
_____	_____	_____

