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		Yes	No	
☐	☐	Do your gums bleed when you brush?	☐	☐	Have you ever had orthodontic (braces) treatment?
☐	☐	Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	Do you have headaches, earaches or neck pain?
☐	☐	Have you had any periodontal (gum) treatments?	☐	☐	Do you wear removable dental appliances?
☐	☐	Have you had a serious/difficult problem associated with any previous dental treatment? If so, explain _____			

_____

How would you describe your current dental problem?_____

Date of your last dental exam? _____Date of last x-rays_____

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?**

What medicine(s) are you taking?

Prescribed		Over the counter	Natural or herbal preparations
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

☐	☐	☐	**Do you or have you taken blood thinners?**
☐	☐	☐	**Do you or have you taken medication for bone density?**
☐	☐	☐	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		Yes	No		Yes	No		Yes	No	
☐	☐	Local anesthetics	☐	☐	Barbiturates, sedatives or sleeping pills	☐	☐	Latex	☐	☐	Animals
☐	☐	Aspirin	☐	☐	Sulfa Drugs	☐	☐	Iodine	☐	☐	Food (specify)
☐	☐	Penicillin/other antibiotics	☐	☐	Codeine/other narcotics	☐	☐	Hay Fever/seasonal	☐	☐	Other (specify)

To yes responses, specify type of reaction_____

Please complete both sides

Yes No

☐ ☐ 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?

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

Smile....it's good for business
David C. Circeo DDS