



HEALTH HISTORY

DATE ____-____-____ PATIENT NAME _____

AGE _____ SEX M / F HEIGHT _____ WEIGHT LBS. _____

In case of an emergency, contact (person) _____

Phone # () _____ - _____

INSTRUCTIONS:

Answer all questions and fill in the blank spaces when indicated. Answers to the following questions are for our records only and will be kept confidential.

Why are you here today? _____

When was your last visit to a dental office? ____/____/____

PRIOR DENTIST'S NAME and PHONE NUMBER: _____ () _____

When were your last dental x-rays taken? ____/____/____

Are those x-rays available? Yes No

- 1. Are you in poor health? Yes No
- 2. Have you had any serious illness, an operation, or hospitalization in the last 5 years? Yes No
If so, what was the problem? _____
- 3. Are you pregnant? Yes No
- 4. Do you have allergies, hives or a skin rash? Yes No
- 5. Are you allergic to latex or rubber products? Yes No
- 6. Do you have any blood disorder such as anemia? Yes No

- 7. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your mouth, head or neck? Yes No
- 8. Are you employed in any situation that exposes you regularly to x-rays or other ionizing radiation? Yes No
- 9. Do you have or are you being treated for tuberculosis? Yes No
- 10. Do any of your teeth hurt? Which ones? Yes No
- 11. Do you wear a partial denture or any other removable dental appliance? Yes No

1. Has there been any change in your general health within the past year? Yes No

2. Are you currently under the care of a physician? Yes No
A. If so, what is the condition being treated _____

3. The name and address of my physician is _____

- 4. Do you have or have you had any of the following diseases or problems:
 - A. Damaged heart valves or artificial heart valves Yes No
 - B. Congenital heart lesions or murmurs Yes No
 - C. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke, or other) Yes No
 - 1) Do you have pain in your chest upon exertion? Yes No
 - 2) Are you ever short of breath after mild exercise? Yes No
 - 3) Do your ankles swell? Yes No
 - 4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep? Yes No
 - 5) Do you have a cardiac pacemaker? Yes No
 - D. Low blood pressure Yes No
 - E. Sinus trouble Yes No
 - F. Asthma Yes No
 - G. Emphysema or respiratory problems Yes No
 - H. Persistent cough or cough up blood Yes No
 - I. Fainting spells or seizures Yes No
 - J. Diabetes Yes No
 - 1) Do you urinate (pass water) more than 6 times a day? Yes No
 - 2) Are you thirsty much of the time? Yes No
 - 3) Does your mouth frequently become dry? Yes No
 - K. Kidney trouble Yes No
 - L. Stomach troubles/ulcers Yes No
 - M. Hepatitis, jaundice or liver disease Yes No
 - N. Sexually transmitted disease Yes No
 - O. HIV/AIDS Yes No
 - P. Herpes Yes No
 - Q. Arthritis or painful, swollen joints Yes No
 - R. Do you have a prosthetic hip joint prosthesis
implants bone plates or screws
other _____

- 5. Have you had abnormal bleeding associated with previous surgery, trauma or dental extractions? Yes No
A. Do you bruise easily? Yes No
B. Have you ever required a blood transfusion? Yes No
If so, explain the circumstances _____

- 6. Do you use or have you used any of the following:
 - 1. Tobacco: smoke _____ smokeless (chewing) _____ Yes No
Quantity per day _____
 - 2. Alcohol _____ Quantity per day _____ Yes No
 - 3. Recreational drugs Yes No

- 7. Have you taken the diet medication Redux® (Fen-Phen)? Yes No
- 8. Are you taking any medications Yes No
If yes, indicate which.
Antibiotics or sulfa drugs Anticoagulants (blood thinners)
Medicine for high blood pressure Cortisone (steroids)
Antidepressants Sedatives Antihistamines Aspirin
Insulin, tolbutamide (orinase) or similar drug
Digitalis or drugs for heart trouble Nitroglycerin
Oral contraceptives or other hormonal therapy
Medications to treat osteoporosis such as Fosamax, Aredia, Boniva, Zometa (Bisphosphonates) Herbal remedies
Any other drug or medicine _____

- 9. Are you allergic or have you reacted adversely to any of the following:
 - Local anesthetics Yes No
 - Penicillin or other antibiotics Yes No
 - Sulfa drugs Yes No
 - Barbiturates, sedatives or sleeping pills Yes No
 - Aspirin Yes No
 - Iodine Yes No
 - Codeine or other narcotics Yes No
 - Nickel or other metals Yes No
 - Other allergies _____ Yes No
- 10. Are you wearing contact lenses? Yes No
- 11. Do you have any problems associated with your menstrual period? Yes No
- 12. Are you nursing? Yes No
- 13. Do you have any disease, condition, or problem not listed above that you think I should know about? Yes No

Healthy Life Dental

121 W. Colorado Blvd., Monrovia, CA 91016

Tel: (626) 256-3368, Fax: (626) 256-1200, e-mail: info@healthylifedentalcare.com, Web: www.healthylifedentalcare.com

DENTAL HISTORY :

- 14. Is there anything about your teeth or smile that you would like to change? Yes No
If so, explain _____
- 15. Have you had any serious trouble associated with any previous dental treatment? If so, explain _____ Yes No
- 16. How often do you brush your teeth? _____ When? _____
- 17. How often do you floss? _____ When? _____
- 18. Do your gums bleed or hurt?..... Yes No
- 19. Are any of your teeth sensitive to:
Hot Cold Sweets Pressure Yes No
- 20. Does food get caught in your teeth?..... Yes No
- 21. Do you have frequent headaches neck aches or shoulder aches? Yes No
- 22. Do you clench or grind your teeth?..... Yes No
- 23. Have you experienced any pain or soreness in the muscles of your face or around your ear? Yes No
- 24. Does your jaw click or pop?..... Yes No
- 25. Do you wear any type of denture or partial denture?..... Yes No
A. Date of placement ____ / ____ / ____
B. Is there anything about the denture that you would like to change? Yes No

FOLLOW UP to Medical History by DENTIST ONLY _____

I hereby certify that I have read the foregoing and have filled out this health questionnaire completely. I have advised you of all medical problems of which I am aware. I further certify that I, the undersigned, consent to the performing of x-rays and examination.

SIGNATURE OF **PATIENT** or **Guardian** if patient is a minor _____ DATE ____ - ____ - ____

SIGNATURE OF **DENTIST** _____ DATE ____ - ____ - ____

	DATE	COMMENTS	DR. SIGNATURE	EMPLOYEE#	PATIENT SIGNATURE
UPDATE					

Healthy Life Dental

121 W. Colorado Blvd., Monrovia, CA 91016

Tel: (626) 256-3368, Fax: (626) 256-1200, e-mail: info@healthylifedentalcare.com, Web: www.healthylifedentalcare.com