

# Health History Form

E-mail: \_\_\_\_\_

Today's Date:     /     /

As required by law, our office adheres to written policies 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.

Name :	Home Phone <small>include area code</small>	Business/Cell Phone <small>include area code</small>
Last                      First                      Middle	(     )	(     )

Address:	City:	State:	Zip:
Mailing Address			

Occupation:	Height:	Weight:	Date of Birth:	Sex: M    F
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SS# or Patient ID:	Emergency Contact:	Relationship:	Home Phone: (     )	Cell Phone: (     )
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If you are completing this form for another person, what is your relationship to that person:

Your Name:	Relationship:
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**Do you have any of the following diseases or problems? (Check DK if you Don't Know the answer to the question)    Yes    No    DK**

Do you have active tuberculosis or have you been exposed to anyone with active tuberculosis?.....	□	□	□
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## Dental Information *For the following questions, please mark (X) your responses to the following questions:*

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?.....	□	□	□	Do you have earaches or neck pain?.....	□	□	□
Are your teeth sensitive to cold, hot, sweets or pressure?..	□	□	□	Do you have any clicking, popping, or discomfort in the jaw?	□	□	□
Does food or floss catch between your teeth?.....	□	□	□	Do you brux or grind your teeth?.....	□	□	□
Is your mouth dry?.....	□	□	□	Do you have sores or ulcers in your mouth?.....	□	□	□
Have you had any periodontal ( gum ) treatments?.....	□	□	□	Do you wear dentures or partials?.....	□	□	□
Have you had orthodontic ( braces ) treatment?.....	□	□	□	Do you participate in active recreational activities?.....	□	□	□
Have you had any problems associated with any previous dental Treatment?.....	□	□	□	Have you ever had a serious injury to your head or mouth?.	□	□	□
Is your home water supply fluoridated?.....	□	□	□	Date of your last dental exam:			
Do you drink bottled or filtered water?.....	□	□	□	What treatment did you receive at that time?			
If yes, how often? Circle on: DAILY/WEEKLY/OCCASIONALLY				Date of last dental x-rays:			
Are you currently experiencing dental pain or discomfort?..	□	□	□				

What is the reason for your dental visit today:	How do you feel about your smile?
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## Medical Information *For the following questions, please mark (X) your responses to the following questions:*

	Yes	No	DK		Yes	No	DK
Are you now under the care of a physician?.....	□	□	□	Have you had a serious illness, operation or been hospitalized in the past 5 years? .....	□	□	□
Physician Name: _____				If yes, what was the illness or problem?			
Phone: <small>Include area code</small> _____							
Address/City/State/Zip: _____				Are you taking or have you recently taken any prescription or over the counter medicine ( s ) ?.....	□	□	□
Are you in good health?.....	□	□	□	If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:			
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:				-----			

# Medical Information Continued

For the following questions, please mark (X) your responses to the following questions:

( Check DK if you Don 't Know the answer to the question )

<b>Yes No DK</b>	
Do you wear contact lenses?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax©) or risedronate (Actonel©) for osteoporosis or Paget's disease?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia© or Zometa©) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

	<b>Yes No DK</b>
Do you use controlled substances (drugs)?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you use tobacco (smoking, snuff, chew, bidis)?..... If so, how interested are you in stopping? ( Circle One ) VERY / SOMEWHAT / NOT INTERESTED	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>FOR WOMEN ONLY</b> Are you:	
Pregnant?..... If yes, number of weeks _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Taking birth control pills or hormonal replacement?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Nursing?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Date: \_\_\_\_\_ If yes, have you had any complications?.....

**Allergies**—Are you allergic to or have you had a reaction to: **Yes No DK**

To all **yes** responses, specify type of reaction.

Local anesthetics \_\_\_\_\_

Aspirin \_\_\_\_\_

Penicillin or other antibiotics \_\_\_\_\_

Barbiturates, sedatives, or sleeping pills \_\_\_\_\_

Sulfa drugs \_\_\_\_\_

Codeine or other narcotics \_\_\_\_\_

**Yes No DK**

Metals \_\_\_\_\_

Latex (rubber) \_\_\_\_\_

Iodine \_\_\_\_\_

Hay Fever/seasonal \_\_\_\_\_

Animals \_\_\_\_\_

Food \_\_\_\_\_

Other \_\_\_\_\_

Please mark (X) your response to indicated if you have or have not had any of the following diseases or problems.

Yes	No	DK	Yes	No	DK	Yes	No	DK	Yes	No	DK		
Heart murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain upon exertion....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapsed.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, specify _____			
Artificial heart valves.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I or II.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, specify _____			
Angina.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent infections.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G.E. Reflux/persistent heartburn.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type of infection: _____			
Congestive heart failure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronary artery disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid probems.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent swollen glands in neck.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice or liver disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe headaches/migraines... Severe or rapid weight loss....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease... Excessive urination.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart defects.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells or seizures....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
Rheumatic heart disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
Abnormal bleeding.....													

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 I should know about?** .....

If yes, please explain: \_\_\_\_\_

**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 each page of the health history form above and that the information given on this form in its entirety 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. I authorize the release any information including the diagnosis and the records of my treatment or examination rendered to my child or me during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance carrier or dental benefit plan administrator to pay directly to the dentist any dental insurance or benefits otherwise payable to me. I understand that my dental insurance carrier/benefit plan may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my or my dependent's behalf.

X \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Signature of patient or parent, if minor

**FOR COMPLETION BY DENTIST**

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_