Health History

Date _____

NOTE: Please fill out BOTH sides of this form. Your information is confidential.
If you are filling out this form for another person, please state your relationship to the patient
……

Name…… Birthdate……
Home Address……
City…… State…… Zip……
Home Phone…… Work Phone……
Cell Phone…… Email……
Social Security Number/Insurance I.D. Number……
Employer/School & Occupation……
Your Spouse's Name…… Birthdate……
Spouse's Social Security Number/Insurance I.D. Number……
Whom may we thank for your referral? ……
Name & Phone Number of Emergency Contact……
Name & Phone Number of Physician……
Name of Pharmacy……
Reason for today's visit……
Name of Former Dentist……
City/State……
Date of last dental visit/dental x-rays ……
How often do you brush/floss? ……
Are you interested in sedation dentistry? Yes No
Past history of orthodontics/braces? Yes No Periodontal/Gum treatment? Yes No
Are you aware of any dental problems or conditions (pain/discomfort)? Yes No
If yes please explain: ……
Do you have any specific dental concerns? Yes No
If yes please explain: ……
Have you ever been advised to take antibiotics prior to your dental treatment? Yes No
For what reason? ……
Have you been hospitalized in the past 5 years? Yes No
For what reason? ……

Please list any medicines/supplements you are taking and dosages—please include over the counter medicines, vitamins and herbal supplements:
……
……
……

Do you consume grapefruits, grapefruit juice, or grapefruit extract? Yes No

Do you take antacids? Yes No

Are you a smoker? Yes No
Please circle all that apply: cigarettes pipe cigars marijuana

Height: _____ Weight: _____Lbs.

Women: Are you pregnant or planning a pregnancy? Yes No Date due: _____
Are you a nursing mother? Yes No
Are you taking oral contraceptives? Yes No

ALL PATIENTS: Are you sensitive or allergic to any of the following?

Aspirin	YES	NO	Local Anesthesia	YES	NO
Codeine	YES	NO	Nickel or other metals	YES	NO
Erythromycin/Zithromax	YES	NO	Nuts or Food	YES	NO
Ibuprofen or Tylenol	YES	NO	Penicillin	YES	NO
Iodine	YES	NO	Sulfa	YES	NO
Latex or Rubber	YES	NO	Tetracycline	YES	NO

Other (specify)_____

Please circle whether you currently have, or have ever had, any of the following:

Abnormal Bleeding	YES	NO	Tuberculosis	YES	NO
Blood Disease	YES	NO	Autoimmune Disease	YES	NO
Blood Transfusion	YES	NO	Cancer/Chemo/Radiation	YES	NO
Anemia	YES	NO	Type and Date: _____		
Hemophilia	YES	NO	Celiac Disease	YES	NO
High Blood Pressure	YES	NO	Organ Transplant	YES	NO
Low Blood Pressure	YES	NO	Type and Date: _____		
Jaundice/Liver Disease	YES	NO	Dementia/Alzheimer's	YES	NO
Hepatitis—A,B or C	YES	NO	Diabetes	YES	NO
Kidney Disease/Dialysis	YES	NO	Type:_____		
Aids/HIV	YES	NO	Epilepsy/Seizures	YES	NO
STD/Venereal Disease	YES	NO	Mental Health Problems	YES	NO
Arthritis	YES	NO	Psychiatric Care	YES	NO
Artificial Joints	YES	NO	Neurological Disorders	YES	NO
Type and when placed? _____			Drug/Alcohol Dependency	YES	NO
Heart Disease/Murmur	YES	NO	Glaucoma	YES	NO
Congenital Heart Problem	YES	NO	Osteopenia/Osteoporosis	YES	NO
Heart Attack/Failure	YES	NO	Stomach Problems/Reflux	YES	NO
Angina	YES	NO	Ulcers	YES	NO
Artificial Heart Valve	YES	NO	Tumor/Growth on Head or Neck	YES	NO
Pacemaker/Stent	YES	NO	Swollen Neck Glands	YES	NO
Any other heart problem	YES	NO	Thyroid problems	YES	NO
Rheumatic Fever	YES	NO	Vertigo/Dizzy Spells	YES	NO
Stroke	YES	NO	Asthma/Hay Fever	YES	NO
Endocarditis	YES	NO	Emphysema	YES	NO
Mitral Valve Prolapse	YES	NO	Persistent Cough/Respiratory Disease	YES	NO

Do you have any other disease, condition or problem not mentioned, that you think the Doctor needs to know about?

Please explain…….....
…….....
.....

Signature…… Date…..…….....

Provider Signature…….....……....