Health History Form

E-mail: Today's Date:

As required by law, our office adheres to written policies and procedures 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: Last First Middle | Home Phone ( ) | Cell Phone ( )

Address | City | State | Zip

Mailing Address

Occupation | Height | Weight | Date of Birth | Sex: M F

SS# | Emergency Contact | Relationship | Home Phone ( ) | Cell Phone ( )

If you are completeing this form for another person, what is your relationship to that person?

Your Name | Relationship

Do you have any of the following diseases or problems:

	Yes	No
Active Tuberculosis	❑	❑
Persistent cough greater than a 3 week duration	❑	❑
Cough that produces blood	❑	❑
Been exposed to anyone with tuberculosis	❑	❑

How did you hear about us? ❍ Insurance ❍ Ad ❍ Our Website ❍ Drove By ❍ Community Event_____ ❍ Referral: By Who_____

Dental Information *For the following questions, please mark (X) your response to the following questions.*

	Yes	No
Are your teeth sensitive to cold, hot, sweets or pressure?	❑	❑
Is your mouth dry?	❑	❑
Have you had any periodontal (gum) treatments?	❑	❑
Is your home water supply fluoridated?	❑	❑
Are you currently experiencing dental pain or discomfort?	❑	❑
Do you have any clicking, popping or discomfort in the jaw?	❑	❑
Do you brux or grind your teeth?	❑	❑

	Yes	No
Do you have sores or ulcers in your mouth?	❑	❑
Have you ever had a serious injury to your head or mouth?	❑	❑

Date of our last dental exam: _____

What was done at that time? _____

_____

Date of Last dental x-rays _____

What is the reason for your dental visit today?

_____

How do you feel about your smile?

_____

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

	Yes	No
Are you now under the care of a physician?	❑	❑

Physician name: Phone: ( )

Address/City/State/Zip

	Yes	No
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:

	Yes	No
Have you had a serious illness, operation or been hospitalized in the past 5 years?	❑	❑

If yes, what was the illness or problem?

Please list all prescription and non-prescription medications you are currently taking:

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

	Yes	No
Are you currently using A CPAP Machine?	❑	❑
Have you had an orthopedic total join (hip, knee, elbow) replacement?	❑	❑
Date: _____		
If yes, have you had any complications?	❑	❑

Are you taking or scheduled to begin taking either an intravenous or oral bisphosphonate such as:
Alendronate (Fosamax), Risedronate (Actonel), Ibandronic Sodium (Boniva), Aredia or Zometa ❑ ❑
Date treatment began: _____

	Yes	No
Do you use controlled substances? (Drugs)	❑	❑
Do you use tobacco (smoking, snuff, chew, bidis)?	❑	❑
If so, how interested are you in stopping? (circle one) VERY / SOMEWHAT / NOT INTERESTED		
Did you drink alcohol in the last 24 hours?	❑	❑

WOMEN ONLY Are you:

Pregnant?	❑	❑
Number of weeks? _____		
Taking birth control pills or hormonal replacement?	❑	❑
Nursing?	❑	❑

Allergies - Are you allergic to or have you had a reaction to:
To all YES responses, specify type of reaction:

	Yes	No
Local anesthetics _____	❑	❑
Aspering / Ibuprofen / Tylenol _____	❑	❑
Penicilin or other antibiotics _____	❑	❑
Sulfa drugs _____	❑	❑
Codeine or other narcotics _____	❑	❑
Metals _____	❑	❑
Latex (rubber) _____	❑	❑
Iodine _____	❑	❑
Food _____	❑	❑

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

	Yes	No
Are you currently taking an anticoagulant or blood thinning medication?	❑	❑
Artificial (Prosthetic) heart valve	❑	❑
Previous infective endocarditis	❑	❑
Damaged valves in transplanted heart	❑	❑
Congenital heart disease (CHD)	❑	❑
Unrepaired, cyanotic CHD	❑	❑
Repaired (completely) in last 6 months	❑	❑
Repaired CHD with residual defects	❑	❑

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD

	Yes	No
Cardiovascular disease	❑	❑
Angina	❑	❑
Arterioschlerosis	❑	❑
Congestive heart failure	❑	❑
Damaged heart valves	❑	❑
Heart attack	❑	❑
Heart murmur	❑	❑
Low blood presure	❑	❑
High blood pressure	❑	❑
Other congenital heart defects	❑	❑
Mitral valve prolapse	❑	❑
Pacemaker	❑	❑
Rheumatic fever	❑	❑
Rheumatic hert disease	❑	❑
Abnormal bleeding	❑	❑
Anemia	❑	❑
Blood transfusion	❑	❑
If yes, date _____		
Hemophelia	❑	❑
Aids or HIV infection	❑	❑
Arthritis	❑	❑
Auto Immune disease	❑	❑
Rheumatoid arthiritis	❑	❑
Systemic lupus erythematosus	❑	❑
Asthma	❑	❑
Bronchitis	❑	❑
Emphysema	❑	❑
Sinus Trouble	❑	❑
Tuberculosis	❑	❑
Cancer/Chemotherapy/ Radiation Treatment	❑	❑
Chest pain upon exertion	❑	❑
Chronic pain	❑	❑
Diabetes Type I or II	❑	❑
Eating disorder	❑	❑
Malnutrition	❑	❑
Gastrointestinal disease	❑	❑
G.E. Reflux/persistent heartburn	❑	❑
Ulcers	❑	❑
Thyroid problems	❑	❑
Stroke	❑	❑
Glaucoma	❑	❑
Hepatitis, jaundice or liver disease	❑	❑
Epilepsy	❑	❑
Fainting spells or seizures	❑	❑
Neurological disorders	❑	❑
If yes, specify: _____		
Sleep disorder	❑	❑
Mental health disorders	❑	❑
If yes, specify: _____		
Recurrent Infections	❑	❑
Type of Infection: _____		
Kidney problems	❑	❑
Osteoporosis	❑	❑
Persistent swollen glands in neck	❑	❑
Severe headaches/migranes	❑	❑
Sexually transmitted disease	❑	❑
Excessive urination	❑	❑

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ❑ ❑

Name of physician or dentist making recommendation: _____

Do you have any disease, condition, or problem not listed above that you think I should know about? ❑ ❑

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 the above and that the information given on this form 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 acknowlede 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 acton they take or do not take because of errors or omissions that I may have made in the completion of this form.

Print Name:	Signature of Patient/Legal Guardian:	Date:

FOR COMPLETION BY DENTIST

Date:	Changes: Yes	No	Changes to HHX are listed below	Patient Signature	Provider Initials
1.	❑	❑			
2.	❑	❑			
3.	❑	❑			
4.	❑	❑			