

# Health History Form

Email: \_\_\_\_\_ 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: _____			Home Phone: <i>Include area code</i> ( )		Business/Cell Phone: <i>Include area code</i> ( )	
Last	First	Middle	City:		State:	Zip:
Address: _____ <i>Mailing address</i>			Occupation:		Height:	Weight:
SS# or Patient ID:			Emergency Contact:	Relationship:	Home Phone: <i>Include area code</i> ( )	Cell Phone: <i>Include area code</i> ( )
If you are completing this form for another person, what is your relationship to that person?						
Your Name			Relationship			
<b>Do you have any of the following diseases or problems:</b>						<b>Yes No DK</b>
Active Tuberculosis.....						☐ ☐ ☐
Persistent cough greater than a 3 week duration.....						☐ ☐ ☐
Cough that produces blood.....						☐ ☐ ☐
Been exposed to anyone with tuberculosis.....						☐ ☐ ☐
<b>If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.</b>						

## 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 pains?.....	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?.....	☐	☐	☐	Do you have any clicking, popping or discomfort in the jaw?.....	☐	☐	☐
Is your mouth dry?.....	☐	☐	☐	Do you brux or grind your teeth?.....	☐	☐	☐
Have you had any periodontal (gum) treatments?.....	☐	☐	☐	Do you have sores or ulcers in your mouth?.....	☐	☐	☐
Have you ever had orthodontic (braces) treatment?.....	☐	☐	☐	Do you wear dentures or partials?.....	☐	☐	☐
Have you had any problems associated with previous dental treatment?.....	☐	☐	☐	Do you participate in active recreational activities?.....	☐	☐	☐
Is your home water supply fluoridated?.....	☐	☐	☐	Have you ever had a serious injury to your head or mouth?.....	☐	☐	☐
Do you drink bottled or filtered water?.....	☐	☐	☐	Date of your last dental exam:			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY				What was done at that time?			
Are you currently experiencing dental pain or discomfort?.....	☐	☐	☐	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	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: <i>Include area code</i> ( )							
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 dietary 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

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

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

Yes No DK

Do you wear contact lenses?

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

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

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax<sup>®</sup>, Actonel<sup>®</sup>, Atelvia, Boniva<sup>®</sup>, Reclast, Prolia) for osteoporosis or Paget's disease?

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia<sup>®</sup>, Zometa<sup>®</sup>, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?

Date Treatment began: \_\_\_\_\_

**Allergies.** Are you allergic to or have you had a reaction to: To all **yes** responses, specify type of reaction.

Yes No DK

Local anesthetics

Aspirin

Penicillin or other antibiotics

Barbiturates, sedatives, or sleeping pills

Sulfa drugs

Codeine or other narcotics

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

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? \_\_\_\_\_

**WOMEN ONLY** Are you:

Pregnant?

Number of weeks: \_\_\_\_\_

Taking birth control pills or hormonal replacement?

Nursing?

Metals

Latex (rubber)

Iodine

Hay fever/seasonal

Animals

Food

Other

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

Yes No DK

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 DK

Cardiovascular disease

Angina

Arteriosclerosis

Congestive heart failure

Damaged heart valves

Heart attack

Heart murmur

Low blood pressure

High blood pressure

Other congenital heart defects

Yes No DK

Mitral valve prolapse

Pacemaker

Rheumatic fever

Rheumatic heart disease

Abnormal bleeding

Anemia

Blood transfusion

If yes, date: \_\_\_\_\_

Hemophilia

AIDS or HIV infection

Arthritis

Yes No DK

Autoimmune disease

Rheumatoid arthritis

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

Yes No DK

Glaucoma

Hepatitis, jaundice or liver disease

Epilepsy

Fainting spells or seizures

Neurological disorders

If yes, specify: \_\_\_\_\_

Sleep disorder

Do you snore?

Mental health disorders

Specify: \_\_\_\_\_

Recurrent Infections

Type of infection: \_\_\_\_\_

Kidney problems

Night sweats

Osteoporosis

Persistent swollen glands in neck

Severe headaches/migraines

Severe or rapid weight loss

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: \_\_\_\_\_

Phone: Include area code  
( )

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 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.

Signature of Patient/Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Dentist: \_\_\_\_\_

Date: \_\_\_\_\_

FOR COMPLETION BY DENTIST

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