

Health History Form

Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that you 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 will 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	()	()	()
Address:			City:	State:	Zip:
Mailing Address					
Occupation:		Height:	Weight:	Date of Birth:	Sex M F
SS#	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

Do you have any of the following diseases or problems:	<i>(Check DK if you Don't Know the answer to the question)</i>			Yes	No	DK
Active Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough greater than a 3 week duration.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough that produces blood.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been exposed to anyone with tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does food or floss catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam:			
Do you drink bottled or filtered water?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What was done at that time?			
If yes, how often? Circle one: DAILY/WEEKLY/OCCASIONALLY				Date of last dental x-rays:			
Are you currently experiencing dental pain or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician Name: Phone: <i>Include area code</i>				If yes, what was the illness or problem?			
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 Please mark (x) your response to indicate if you have or have not had any of the following diseases or problems.

<i>(Check DK if you Don't Know the answer to the question)</i>			Yes No DK				Yes No DK
Do you wear contact lenses?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you use controlled substances (drugs)?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Joint replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you use tobacco (smoking, snuff, chew, bidis)?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Date: _____ If yes, have you had any complications?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If so, how interested are you in stopping?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				(Circle one) VERY / SOMEWHAT / NOT INTERESTED			<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"/>	Do you drink alcoholic beverages?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				If yes, how much alcohol did you drink in the last 24 hours? _____			
				If yes, how much do you typically drink in a week? _____			
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"/>	WOMEN ONLY Are you:			
Date Treatment began: _____				Pregnant?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Number of weeks: _____			
				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"/>
Allergies- Are you allergic to or have you had a reaction to :			Yes No DK				Yes No DK
To all yes responses, specify type of reaction.				Metals _____			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Local anesthetics _____			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Latex (rubber) _____			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Aspirin _____			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Iodine _____			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Penicillin or other antibiotics _____			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hay fever/seasonal _____			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills _____			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Animals _____			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Sulfa drugs _____			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Food _____			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Codeine or other narcotics _____			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Other _____			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Please mark (x) your response to indicate if you have or have not had any of the following disease or problems.							
			Yes No DK				Yes No DK
Artificial (prosthetic) heart valve			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Autoimmune disease			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Previous infective endocarditis			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rheumatoid arthritis			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Damaged valves in transplanted heart			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Systemic Lupus erythematosus			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Congenital heart disease (CHD)				Asthma			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Unrepaired, cyanotic CHD			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Bronchitis			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Repaired (completely) in last 6 months			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Empysemata			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Repaired CHD with residual defects			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sinus trouble			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Tuberculosis			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD</i>				Cancer/Chemotherapy/			
				Radiation Treatment			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Chest pain upon exertion			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Chronic pain			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Diabetes Type I or II			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Eating disorder			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Malnutrition			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Gastrointestinal disease			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				G.E. reflux/persistent			
				heartburn			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Ulcers			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Thyroid problems			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Stroke			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Glaucoma			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Hepatitis, jaundice or			
				liver disease			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Epilepsy			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Fainting spells or seizures			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Neurological disorders			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				If yes, specify: _____			
				Sleep disorder			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Mental health disorders			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Specify: _____			
				Recurrent Infections			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Type of infection: _____			
				Kidney problems			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Night sweats			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Osteoporosis			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Persistent swollen glands			
				in neck			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Severe headaches/			
				migraines			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Severe or rapid weight loss			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Sexually transmitted disease			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Excessive urination			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cardiovascular disease			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Mitral valve prolapse			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Angina			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Pacemaker			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Arteriosclerosis			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rheumatic fever			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Congestive heart failure			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rheumatic heart disease			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Damaged heart valves			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Abnormal bleeding			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Heart attack			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Anemia			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Heart murmur			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Blood transfusion			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Low blood pressure			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If yes, date: _____			
High blood pressure			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hemophilia			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Other congenital heart				AIDS or HIV infection			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
defects			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Arthritis			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?							
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>							
Name of physician or dentist making recommendation:				Phone			
Do you have any disease, condition, or problem not listed above that you think I should know about?							
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>							
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 healthy 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 _____

FOR COMPLETION BY DENTIST

Comments: _____
