

Health History Form

Name: _____ 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.

DENTAL INFORMATION

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

	Yes	No	DK
Do you smoke cigarettes, pipes or cigars?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when you brush or floss?	<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"/>
Is your mouth dry?	<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"/>
Have you ever had orthodontics (braces) treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink bottled or filtered water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No	DK
Do you have earaches or neck pains?	<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"/>
Do you brux or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a bite guard appliance?	<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"/>
Do you wear dentures or partials?	<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"/>

When was your last dental exam?

When were your last x-rays?

How may we improve your smile? _____

How do you feel about your smile? _____

MEDICAL INFORMATION

	Yes	No	DK
Are you now under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physicians Name: _____ Phone: include area code () _____			

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Address / City / State / Zip: _____

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter meds?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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If so, please list all medications including vitamins, natural or herbal preparations and/or dietary supplements:

Has there been any change in your general health the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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If yes, what condition is being treated?

Date of last physical exam: _____

	Yes	No	DK
Artificial (prosthetic) heart valve?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous infective endocarditis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No	DK
Damaged valves in transplanted heart?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease (CHD)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL INFORMATION

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

	Yes	No	DK
Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint Replacement. Have you had an orthopedic total or partial joint (hip, knee, elbow, finger) replacement?	<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"/>
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax*, Actonel*, Atelvia, Boniva*, Reclact, Prolia) for osteoporosis or Paget's disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Since 2001, were you treated or you presently scheduled to begin treatment with an antiresorptive agent (like Aredia*, Zometa* XGEVA) 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"/>
Date Treatment Began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use tobacco (smoking, snuff, chew)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how much do you typically drink in a week? _____			

WOMEN ONLY Are you:

Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, 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:
To all **YES** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No	DK
Sulfa drugs / Iodine _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metals _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<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?

If yes, name of physician or dentist making recommendation: _____ Phone: (_____) _____

	Yes	No	DK		Yes	No	DK		Yes	No	DK				
Cardiovascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition	<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"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atherosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<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"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<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"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<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"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain upon exertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells or seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<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"/>
Other Heart defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you Snore	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, Date: _____				If yes, specify: _____				If yes, specify: _____				Type of infection: _____			
Hepatitis, jaundice or liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe headaches / migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer / Chemotherapy / Radiation treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G.E. Reflux / persistent heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent swollen glands in the neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus	<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"/>
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"/>	Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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: _____