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 questionaire 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?	☐	☐	☐
Do you gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontics (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatments?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: ◯ DAILY ◯ WEEKLY ◯ OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have a bite guard appliance?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

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?	☐	☐	☐

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

Physicians Name: Phone: include area code ( )

If yes, what was the illness or problem?

Address / City / State / Zip:

	Yes	No	DK
Are you taking or have you recently taken any prescription or over the counter meds?	☐	☐	☐

If so, please list all medications including vitamins, natural or herbal preparations and/or dietary supplements:

	Yes	No	DK
Are you in good health?	☐	☐	☐
Has there been any change in your general health the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Artificial (prosthetic) heart valve?	☐	☐	☐
Previous infective endocarditis?	☐	☐	☐

	Yes	No	DK
Damaged valves in transplanted heart?	☐	☐	☐
Congenital heart disease (CHD)?	☐	☐	☐

Cooper Dentistry
general & cosmetic dentistry

MEDICAL INFORMATION

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

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total or partial 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*, Actonel*,Atelvia, Boniva*, Reclact, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
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?	☐	☐	☐

Date Treatment Began: _____

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew)?	☐	☐	☐
If yes, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐

If yes, how much do you typically drink in a week? _____

WOMEN ONLY Are you:

Pregnant?	☐	☐	☐
If yes, 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	DK
Local anesthetics_____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills_____	☐	☐	☐

	Yes	No	DK
Sulfa drugs / Iodine _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

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
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Ateriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other Heart defects	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, Date: _____			
Hepatitis, jaundice or liver disease	☐	☐	☐
Persistent swollen glands in the neck	☐	☐	☐
Kidney problems	☐	☐	☐

	Yes	No	DK
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Severe headaches / migraines	☐	☐	☐
Systemic lupus	☐	☐	☐
Eating disorder	☐	☐	☐
Night sweats	☐	☐	☐

	Yes	No	DK
Rheumatoid arthritis	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
If yes, specify: _____			
Cancer / Chemotherapy / Radiation treatment	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Osteoporosis	☐	☐	☐

	Yes	No	DK
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Sleep disorder	☐	☐	☐
Do you Snore	☐	☐	☐
Recurrent disorders	☐	☐	☐
Type of infection: _____			
G.E. Reflux / persistent heartburn	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

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: _____