HEALTH HISTORY FORM

Name: _______________ Home Phone:( ) _______ Business Phone:( ) _______
Last *First* *Middle*

Address: _______________ City: _______ State: _______ Zip: _______
P.O. Box or Mailing Address

Occupation: _______ Height: _______ Weight: _______ Date of Birth (mm/dd/yy): _______ Sex: M ❑ F ❑

SS#: _______ Emergency Contact: _______ Relationship: _______ Phone:( ) _______

If you are completing this form for another person, what is your relationship to that person? _______
Name *Relationship*

Who referred you to our office? _______ Your E-mail address: _______

Name of your dental insurance: _______ Policy Number: _______

Insurer's address & phone: _______

For the following questions, please (X) whichever applies. Your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit 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 care for you. This office does not use this information to discriminate.

DENTAL INFORMATION

	Yes	No
Do your gums bleed when you brush?	❑	❑
Have you ever had orthodontic (braces) treatment?	❑	❑
Are your teeth sensitive to cold, hot, sweets or pressure?	❑	❑
Do you have earaches or neck pains?	❑	❑
Have you had any periodontal (gum) treatments?	❑	❑
Do you wear removable dental appliances?	❑	❑
Do you grind or clench your teeth?	❑	❑
Do you snore?	❑	❑
Have you had a serious/difficult problem associated with any previous dental treatment?	❑	❑

If yes, explain: _______

How would you describe your current dental problem? _______

Date of your last dental exam: _______
Date of last dental x-rays: _______
What was done at that time? _______

How do you feel about the appearance of your teeth? _______

MEDICAL INFORMATION

	Yes	No
Are you in good health?	❑	❑
Has there been any change in your general health in the past year?	❑	❑
Are you now under the care of a physician?	❑	❑

If yes, what is/are the condition(s) being treated? _______

Date of last physical examination: _______
Physician Information:

NAME _______ PHONE _______
ADDRESS _______
CITY/STATE _______ ZIP _______
NAME _______ PHONE _______
ADDRESS _______
CITY/STATE _______ ZIP _______

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

If yes, what was the illness or problem? _______
Have you had any of the following diseases or problems?

	Yes	No
Active Tuberculosis?	❑	❑
Persistent cough greater than a 3 week duration?	❑	❑
Cough that produces blood?	❑	❑

	Yes	No
Are you taking or have you recently taken any medicine(s) including non-prescription medication?	❑	❑

If yes, what medicine(s) are you taking?
Prescribed: _______

Over the Counter: _______

	Yes	No
Do you drink alcoholic beverages?	❑	❑

If yes, how much alcohol did you drink in the past 24 hours? _______
In the past week? _______

	Yes	No
Are you alcohol and/or drug dependent?	❑	❑
If yes, have you received treatment?	❑	❑
Do you use drugs or other substances for recreational purposes?	❑	❑

If yes, please list: _______
Frequency of use (daily, weekly, etc.) _______
Number of years of recreational drug use: _______
Do you use tobacco (smoking, snuff, chew)? _______
If yes, how interested are you in stopping? _______

	Yes	No
Do you wear contact lenses?	❑	❑

PLEASE COMPLETE BOTH SIDES

Are you allergic to or have you had a reaction to:	Yes	No
Local anesthetics	❑	❑
Aspirin	❑	❑
Penicillin or other antibiotics	❑	❑
Barbiturates, sedatives, or sleeping pills	❑	❑
Sulfa drugs	❑	❑
Codeine or other narcotics	❑	❑
Latex	❑	❑
Iodine	❑	❑
Hay fever/seasonal	❑	❑
Animals	❑	❑
Food (*specify*) ____________	❑	❑
Metals (*specify*) ____________	❑	❑
Other (*specify*) ____________	❑	❑

To yes responses, specify type of reaction: ____________

____

____

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	Yes	No
	❑	❑

If Yes:

When was this operation done? ____________

Have you had any complications or difficulties with your prosthetic joint? If yes, explain: ____________

____

____

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

If Yes, what antibiotic(s) and at what dosage(s)? ____________

____

WOMEN ONLY

Are you or could you be pregnant?	❑	❑
Are you currently nursing?	❑	❑
Taking birth control pills or hormonal replacement?	❑	❑

Please (X) a response to indicate if you have or have not had any of the following diseases or problems. Do not skip any questions.

	Yes	No
Abnormal bleeding	❑	❑
AIDS or HIV infection	❑	❑
Anemia	❑	❑
Arthritis	❑	❑
Asthma	❑	❑
Rheumatoid arthritis	❑	❑
Blood transfusion. If yes, date: ____________	❑	❑
Cancer/Chemotherapy/Radiation treatment	❑	❑
Cardiovascular disease. If yes, specify below:	❑	❑

❑_*Angina* ❑_*Heart attack*
❑_*Arteriosclerosis* ❑_*Heart murmur*
❑_*Artificial heart valves* ❑_*high blood pressure*
❑_*Congenital heart defects* ❑_*Low blood pressure*
❑_*Mitral valve prolapse*
❑_*Congestive heart failure* ❑_*Pacemaker*
❑_*Coronary artery disease* ❑_*Rheumatic heart disease/Rheumatic fever*
❑_*Damaged heart valves*

	Yes	No
Chest pain upon exertion	❑	❑
Chronic pain	❑	❑
Disease, drug or radiation-induced immunosupression	❑	❑
Diabetes. If yes, specify below:	❑	❑
❑ *Type I (Insulin dependent)* ❑ *Type II*		
Dry Mouth	❑	❑
Eating disorder. If yes, specify: ____________	❑	❑
Epilepsy	❑	❑
Fainting spells or seizures	❑	❑
Gastrointestinal disease	❑	❑
G.E. Reflux/persistent heartburn	❑	❑
Glaucoma	❑	❑
Hemophilia	❑	❑
Hepatitis, jaundice or liver disease	❑	❑

	Yes	No
Recurrent infections	❑	❑
If yes, indicate type of infection: ____________		
Kidney problems	❑	❑
Mental health disorders,	❑	❑
If yes, specify: ____________		
Malnutrition	❑	❑
Night sweats	❑	❑
Neurological disorders.	❑	❑
If yes, specify: ____________		
Osteoporosis		
Persistent swollen glands in neck	❑	❑
Respiratory problems. If yes, specify below:	❑	❑
❑ *Emphysema* ❑ *Bronchitis, etc.*		
Severe headaches/migraines	❑	❑
Severe or rapid weight loss	❑	❑
Sexually transmitted disease	❑	❑
Sinus trouble	❑	❑
Sleep disorder	❑	❑
Sores or ulcers in the mouth	❑	❑
Stroke	❑	❑
Sytemic lupus erythematosus	❑	❑
Tuberculosis	❑	❑
Thyroid problems	❑	❑
Ulcers	❑	❑
Excessive urination	❑	❑

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. 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 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 on patient interview concerning health history:

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