

Health History Form



E-mail: _____ Today's Date: _____

Name: Last First Middle Home Phone: include area code Business/Cell Phone: include area code
() ()

Mailing Address: _____ City State Zip

Occupation: _____ Height: _____ Weight: _____ Date of birth: _____ Sex: M F

SS# or Patient ID: _____ Emergency Contact: _____ Relationship: _____ Home Phone: _____ Cell Phone: _____
() () include area codes

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: (Check DK if you Don't Know the answer to the question) Yes No DK

- Active Tuberculosis
- Persistent cough greater than a 3 week duration
- Cough that produces blood
- Been exposed to anyone with tuberculosis

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.

- | | |
|---|---|
| <p>Do your gums bleed when you brush or floss?
Are your teeth sensitive to cold, hot, sweets or pressure?
Does food or floss catch between your teeth?
Is your mouth dry?
Have you had any periodontal (gum) treatments?
Have you ever had orthodontic (braces) treatment?
Have you had any problems associated with previous dental treatment?
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?
What is the reason for your dental visit today?</p> | <p>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 sores or ulcers in your mouth?
Do you wear dentures or partials?
Do you participate in active recreational activities?
Have you ever had a serious injury to your head or mouth?
Date of your last dental exam: _____
What was done at that time?

Date of last dental x-rays: _____</p> |
|---|---|

How do you feel about your smile?

Medical Information

Please mark (X) your response to indicate if you have or have had any of the following diseases or problems.

- | | |
|--|---|
| <p>Are you now under the care of a physician?
Physician's Name: _____ Phone: include area code _____
()
Address/City/State/Zip: _____
_____</p> | <p>Have you had a serious illness, operation or been hospitalized in the past 5 years?
If yes, what was the illness or problem?

_____</p> |
|--|---|

Are you in good health?

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: _____

Pharmacy Name _____

Phone () _____

Medications

List any medications you are currently taking and the correlating diagnosis:

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

Yes No DK

Yes No DK

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?

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?

Date Treatment began: _____

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

Date: _____ If yes, have you had any complications?

Allergies - Are you allergic to or have you had a reaction to:

Local anesthetics _____

Aspirin _____

Penicillin or other antibiotics _____

Barbiturates, sedatives, or sleeping pills _____

Sulfa drugs _____

Codeine or other narcotics _____

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

Yes No DK

Heart murmur

Mitral valve prolapse

Artificial heart valves

Rheumatic fever

Cardiovascular disease

Angina

Arteriosclerosis

Congestive heart failure

Coronary artery disease

Damaged heart valves

Heart attack

Low blood pressure

High blood pressure

Congenital heart defects

Pacemaker

Rheumatic heart disease

Abnormal bleeding

Anemia

Blood transfusion

If yes, date: _____

Hemophilia

AIDS or HIV infection

Arthritis

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

Glaucoma

Hepatitis, jaundice or

liver disease

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 replacements?

Nursing?

Metals _____

Latex (rubber) _____

Iodine _____

Hay fever/seasonal _____

Animals _____

Food _____

Other _____

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

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?

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 have made in the completion of this form.

Signature of Patient/Legal Guardian: _____

Date: _____