Health History Form

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 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.

Name _____ Date of Birth _____

Home ( ) _____ Cell Phone ( ) _____ May we use this number to send text notifications regarding your appointments? YES / NO

Address _____

City State Zip

SSN _____ Emergency Contact _____

Name Ph. # Relationship

Do you have any of the following diseases or problems? (Mark 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 answered yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information (Mark DK if you don't know the answer to the question)

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐	Do you have earaches or neck pains?	☐	☐	☐
Are your teeth sensitivity to cold, hot, sweets or pressure?	☐	☐	☐	Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐	Do you brux or grind your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐	Do you have sores or ulcers in your mouth?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐	Do you wear partials or dentures?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐	Do you participate in recreational activities/sports?	☐	☐	☐
Have you had any problems with previous dental treatment?	☐	☐	☐	Have you ever had a serious injury to your head or mouth?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐	Do you drink bottled/filtered water?	☐	☐	☐
Are you currently experiencing dental pain or discomfort?	☐	☐	☐	Date of your last dental exam and/or x-rays? _____			

Medical Information

Are you now under the care of a physician? Yes / No Physician/Facility Name _____ Ph. # _____

Have you had a serious illness, operation or hospitalization within the past 5 years? Yes / No

If yes, what was the illness or problem? _____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? Yes / No

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

_____

_____

(Continued on other side)

Medical Information (Please indicate if you have or have not had any of the following. Mark DK if you don't know)

	Yes	No	DK
Joint Replacement - Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had complications? (specify) _____			
Are you taking or will you begin taking either: 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?	☐	☐	☐
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, beedis)?	☐	☐	☐
If so, how interested are you in quitting? (Please circle) VERY / SOMEWHAT / NOT INTERESTED			
Do you use e-cigarettes / vape pens?	☐	☐	☐
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much do you typically drink in a week? _____			
If yes, have you had any drinks in the last 24 hours? What amount? _____			

WOMEN ONLY – Are you:

	Yes	No	DK
Pregnant?	☐	☐	☐
If yes, number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies - Are you allergic to or have you had an allergic reaction to any of the following (Please circle if yes & specify type of reaction):

Local anesthetics _____ Metals _____ Food _____
Codeine/Other narcotics _____ Latex (rubber) _____ Iodine _____
Hay fever/Seasonal _____ Animals _____ Aspirin _____
Penicillin/Other antibiotics _____ Sulfa drugs _____
Barbiturates, sedatives or sleeping pills _____ Other_____

Illness / Disease / Condition (Please indicate if you have or have not had any of the following. Mark DK if you don't know)

	Yes	No	DK		Yes	No	DK		Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐	Previous infective endocarditis	☐	☐	☐	Damaged vales in transplanted heart	☐	☐	☐
Congenital heart disease	☐	☐	☐	Cardiovascular disease	☐	☐	☐	Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐	Congestive heart failure	☐	☐	☐	Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐	Heart murmur	☐	☐	☐	Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐	Other congenital heart defects	☐	☐	☐	Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐	Rheumatic fever	☐	☐	☐	Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐	Anemia	☐	☐	☐	Blood transfusion (when?_____)	☐	☐	☐
Hemophilia	☐	☐	☐	AIDS or HIV infection	☐	☐	☐	Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐	Rheumatoid arthritis	☐	☐	☐	Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐	Bronchitis	☐	☐	☐	Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐	Tuberculosis	☐	☐	☐	Cancer/chemotherapy/radiation	☐	☐	☐
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	☐	☐	☐
Epilepsy	☐	☐	☐	Fainting spells or seizures	☐	☐	☐	Neurological disorders	☐	☐	☐
Mental health disorder (specify:_____)	☐	☐	☐	Sleep disorder	☐	☐	☐	Recurrent infections (type:_____)	☐	☐	☐
Kidney problems	☐	☐	☐	Night sweats	☐	☐	☐	Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐	Severe headaches/migraines	☐	☐	☐	Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐	Excessive urination	☐	☐	☐				

	Yes	No	DK
Has a physician or previous dentist recommend 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?	☐	☐	☐

If yes, please explain:_____

NOTE: Both Doctor & patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read & 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 the 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 members of the 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/Guardian: _____ **Date:** _____

FOR COMPLETION BY DENTIST

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