Health History Form

Name:_____ Home (____)_____ Business (__)_____
Last First
Address:_____ City:_____ State:_____ Zip:_____
P.O. Box or Mailing Address
Occupation:_____ Height: _____ Weight:_____ Date of Birth_____/_____/_____ **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

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable law: 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 appropriate care for you. This office does not use this information to discriminate.

Dental Information

Yes	No	Don't Know		Yes	No	Don't Know	
☐	☐	☐	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 headaches, earaches or neck pains?
☐	☐	☐	Have you had any periodontal (gum) treatments?	☐	☐	☐	Do you wear removable dental appliances?
☐	☐	☐	Have you had a serious/difficult problem associated with any previous dental treatment? If so, 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	Don't Know	
☐	☐	☐	Are you in good health?
☐	☐	☐	Has there been any change in your general health within the past year?
			Do you have any of the following diseases or problems? If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.
☐	☐	☐	Active Tuberculosis
☐	☐	☐	Persistent cough greater than a 3 week duration
☐	☐	☐	Cough that produces blood
☐	☐	☐	Are you now under the care of a physician? If so, what is/are the condition(s) being treated?_____ Date of last physical examination:_____ Physician(s)_____ Name Phone Address City/State/Zip _____ Name Phone Address City/State/Zip
☐	☐	☐	Have you had any serious illness, operation, or been hospitalized in the last 5 years? If so, what was the illness or problems?_____
☐	☐	☐	Are you taking or have you recently taken any medicine(s) including non-prescription medicine? If so, what medicine(s) are you taking? Prescribed:_____ Over the counter:_____ Natural or herbal preparations:_____
☐	☐	☐	Have you taken any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?
☐	☐	☐	Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the last 24 hours?_____ In the past month? _____ If yes, _____# of drinks per day for _____# of years.
☐	☐	☐	Are you alcohol and/or drug dependent? If so, have you received treatment? (Check one) ☐ Yes ☐ No
☐	☐	☐	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 so, how interested are you in stopping? (Check one) ☐ Very ☐ Somewhat ☐ Not interested
☐	☐	☐	Do you wear contact lenses?

Allergies: Are you allergic to or have you had a reaction to: (Please fill out both columns)

Yes	No	Don't Know		Yes	No	Don't Know	
☐	☐	☐	Local Anesthetics	☐	☐	☐	Latex
☐	☐	☐	Aspirin	☐	☐	☐	Iodine
☐	☐	☐	Penicillin or other antibiotics	☐	☐	☐	Hay fever/seasonal
☐	☐	☐	Barciturates, sedatives or sleeping pills	☐	☐	☐	Animals
☐	☐	☐	Sulfa Drugs	☐	☐	☐	Food (specify)_____
☐	☐	☐	Cocaine or other narcotics	☐	☐	☐	Other (specify)_____

To yes responses, specify type of reaction _____

Please complete both sides

Yes	No	Don't Know	(Women Only)
☐	☐	☐	Are you pregnant?
☐	☐	☐	Nursing?
☐	☐	☐	Taking birth control pills
☐	☐	☐	Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If so, when was this operation done?_____
☐	☐	☐	Have you had any complications or difficulties with your prosthetic joint?
☐	☐	☐	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? If so, what antibiotic and dose?_____

_____Name of physician or dentist: _____Phone _____

NOTE TO PATIENT: A new report (July 1997) prepared and endorsed by the American Dental Association and the American Academy of Orthopedic Surgeons recommended that antibiotic prophylaxis before dental treatment is not indicated for most dental patients with artificial orthopedic prosthetic joints. This office will glad to discuss this report with you and provide a copy of it to you and your orthopedic surgeon/physician.

Please (X) if you have or had any of the following diseases or problems.

Yes	No	Don't Know		Yes	No	Don't Know		Yes	No	Don't Know	
☐	☐	☐	Abnormal bleeding	☐	☐	☐	Disease, drug, or radiation-	☐	☐	☐	Neurological disorders.
☐	☐	☐	AIDS or HIV infection				induced immunosurpression				If yes, specify_____
☐	☐	☐	Anemia	☐	☐	☐	Diabetes. If yes, specify below:	☐	☐	☐	Osteoporosis
☐	☐	☐	Arthritis	☐	☐	☐	○ Type I (Insulin dependent)	☐	☐	☐	Persistent swollen glands
☐	☐	☐	Rheumatoid Arthritis				○ Type II	☐	☐	☐	Respiratory problems.
☐	☐	☐	Asthma	☐	☐	☐	Dry Mouth				if yes, specify below:
☐	☐	☐	Blood Transfusion	☐	☐	☐	Eating disorder.				○ Emphysema
			If yes, date_____				If yes, specify_____				○ Bronchitis, etc.
☐	☐	☐	Cancer/chemotheraphy/	☐	☐	☐	Epilepsy	☐	☐	☐	Severe headaches
			Radiation treatment	☐	☐	☐	Fainting spells or seizures	☐	☐	☐	Severe or rapid weight loss
☐	☐	☐	Cardiovascular disease	☐	☐	☐	G.E. reflux	☐	☐	☐	Sexually transmitted disease
			If yes, specify below	☐	☐	☐	Glaucoma	☐	☐	☐	Sinus Trouble
			○ Angina	☐	☐	☐	Hemophilia	☐	☐	☐	Sleep disorder
			○ Arteriosclerosis	☐	☐	☐	Hepatitis, jaundice or liver disease	☐	☐	☐	Sores or ulcers in the mouth
			○ Artificial heart valves	☐	☐	☐	Recurrent infections	☐	☐	☐	Strokes
			○ Coronary insufficiency				indicate type of infection	☐	☐	☐	Systemic lupus erythematos
			○ Coronary occlusion				_____	☐	☐	☐	Thyroid problems
			○ Damaged heart valves	☐	☐	☐	Kidney Problems	☐	☐	☐	Tuberculosis
			○ Heart attack	☐	☐	☐	Low Blood pressure	☐	☐	☐	Ulcers
			○ Heart murmur	☐	☐	☐	Mental health disorders	☐	☐	☐	Excessive urination
			○ High blood pressure				If yes, specify below.	☐	☐	☐	Do you have any disease
			○ Inborn heart defects				_____				condition, or problem not listed
			○ Mitral valve prolapsed				_____				above that you think I should
			○ Pacemaker	☐	☐	☐	Malnutrition				know about? Please explain.
			○ Rhuematic heart disease	☐	☐	☐	Migranes				_____
☐	☐	☐	Chest pain upon exertion	☐	☐	☐	Night sweats				_____
☐	☐	☐	Chronic pain	☐	☐	☐	Persistent diarrhea				_____

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 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

For completion by dentist

Comments on patient interview concerning health history _____
Significant findings from questionnaire or oral interview _____
Dental management considerations _____

_____ _____
Signature of Dentist Date