

Health History Form

E-mail: _____

Today's 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 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:			Home Phone: <i>Include area code</i>		Business/Cell Phone: <i>Include area code</i>	
Last	First	Middle	()	()	()	()
Address:			City:		State: Zip:	
Mailing address						
Occupation:			Height:		Weight:	
			Date of birth:		Sex: M F	
SS# or Patient ID:			Emergency Contact:		Relationship:	
			Home Phone:		Cell Phone:	
			()		()	
			<i>include area codes</i>			

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.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough greater than a 3 week duration.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough that produces blood.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been exposed to anyone with tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.*

Please check any of the following problems that apply to you.

- | | |
|--|--|
| <input type="checkbox"/> Sensitivity (hot, cold, sweet) | <input type="checkbox"/> Make them brighter or whiter |
| <input type="checkbox"/> Tooth pain or discomfort when chewing | <input type="checkbox"/> Make them straighter |
| <input type="checkbox"/> Headaches, earaches, neckpain | <input type="checkbox"/> Close spaces |
| <input type="checkbox"/> Jaw joint pain | <input type="checkbox"/> Replace black metal fillings with natural, tooth-colored fillings |
| <input type="checkbox"/> Teeth or fillings breaking | <input type="checkbox"/> Repair chipped teeth |
| <input type="checkbox"/> Grinding or clenching teeth | <input type="checkbox"/> Replace missing teeth |
| <input type="checkbox"/> Bleeding, swollen or irritated gums | <input type="checkbox"/> Replace old crowns that don't match |
| <input type="checkbox"/> Loose, tipped or shifting teeth | <input type="checkbox"/> Have a smile makeover |
| <input type="checkbox"/> Bad breath or bad taste in your mouth | |

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

What is the most important thing to you about your future smile and dental health?

What is the most important thing to you about your dental visit today?

Do you have or have you had any of the following?

- Dentures
- Partial dentures
- Braces
- Peridontal (gum) treatments
- Please share the following dates:
- Your last cleaning _____
- Your last oral cancer screening _____
- Your last complete X-Rays _____

Name of previous Dentist _____ Phone # _____

City _____ State _____

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

Are you now under the care of a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Have you had a serious illness, operation or been hospitalized in the past 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Physician Name: _____ Phone: <i>Include area code</i> () _____	If yes, what was the illness or problem? _____
Address/City/State/Zip: _____	Are you taking or have you recently taken any prescription or over the counter medicine(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Are you in good health? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	If so, please list all medications.
Has there been any change in your general health within the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	_____
If yes, what condition is being treated? _____	_____
Date of last physical exam: _____	_____

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following:

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

	Yes	No	DK		Yes	No	DK
Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use controlled substances (drugs)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use tobacco (smoking, snuff, chew, bidis)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date: _____ If yes, have you had any complications?				If so, how interested are you in stopping?			
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(Circle one) VERY / SOMEWHAT / NOT INTERESTED			
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcoholic beverages?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date Treatment began: _____				If yes, how much alcohol did you drink in the last 24 hours?			

WOMEN ONLY Are you:

Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nursing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

To all yes responses, specify type of reaction.	Yes	No	DK		Yes	No	DK
Local anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Metals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex (rubber)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/seasonal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK		Yes	No	DK		Yes	No	DK
Artificial (prosthetic) heart valve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice or liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous infective endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged valves in transplanted heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus erythematosus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells or seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease (CHD)				Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unrepaired, cyanotic CHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, specify: _____			
Repaired (completely) in last 6 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired CHD with residual defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____			
				Cancer/Chemotherapy/ Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Chest pain upon exertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type of infection: _____			
				Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Diabetes Type I or II	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Malnutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent swollen glands in neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Gastrointestinal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe headaches/migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				G.E. Reflux/persistent heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe or rapid weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
				Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK		Yes	No	DK
Cardiovascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	if yes, date: _____			
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other congenital heart defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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:

I have been advised of Hippa rules and regulations.

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 Parent/Legal Guardian:

Date:

FOR COMPLETION BY DENTIST

Comments: