

Medical ID: <input type="checkbox"/>	Condition: <input type="checkbox"/>	Premedication: <input type="checkbox"/>	Anesthesia: <input type="checkbox"/>	Date: <input type="checkbox"/>
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HEALTH HISTORY FORM

Name: _____ Home Phone: () _____ Business Phone: () _____

Address: _____ City: _____ State: _____ Zip Code: _____
LAST FIRST MIDDLE 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 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 appropriate care for you. This office does not use this information to discriminate.

DENTAL INFORMATION

	Yes	No	Don't Know	
Do your gums bleed when you brush?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How would you describe your current dental problem? _____
Have you ever had orthodontic (braces) treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam: _____
Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of last dental x-rays: _____
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What was done at that time? _____
Do you wear removable dental appliances?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How do you feel about the appearance of your teeth? _____
Have you had a serious/difficult problem associated with any previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes, explain: _____				

MEDICAL INFORMATION

	Yes	No	Don't Know	
If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.				
Have you had any of the following diseases or problems?				
Active Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking or have you recently taken any medicine(s) including non-prescription medicine? <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"/>	If yes, what medicine(s) are you taking? _____
Cough that produces blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prescribed: _____
Are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Over the counter: _____
Has there been any change in your general health within the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vitamins, natural or herbal preparations and/or diet supplements: _____
Are you now under the care of a physician? If yes, what is/are the condition(s) being treated? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Date of last physical examination: _____				Do you drink alcoholic beverages? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Physician: _____				If yes, how much alcohol did you drink in the last 24 hours? _____
NAME PHONE				In the past week? _____
ADDRESS CITY/STATE ZIP				Are you alcohol and/or drug dependent? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
NAME PHONE				If yes, have you received treatment? (circle one) Yes / No
ADDRESS CITY/STATE ZIP				Do you use drugs or other substances for recreational purposes? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any serious illness, operation, or been hospitalized in the past 5 years? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				If yes, please list: _____
If yes, what was the illness or problem? _____ _____ _____				Frequency of use (daily, weekly, etc.): _____
				Number of years of recreational drug use: _____
				Do you use tobacco (smoking, snuff, chew)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				If yes, how interested are you in stopping? (circle one) Very / Somewhat / Not interested
				Do you wear contact lenses? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

	Yes No		Don't Know
	Yes	No	Know
Are you allergic to or have you had a reaction to			
Local anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Iodine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever/seasonal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metals (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

To yes responses, specify type of reaction.

	Yes No		Don't Know
	Yes	No	Know
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, when was this operation done?	_____		
If you answered yes to the above question, 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what antibiotic and dose?	_____		
Name of physician or dentist:	_____		
Phone:	_____		

WOMEN ONLY

Are you or could you be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nursing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking birth control pills or hormonal replacement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

	Yes No		Don't Know		Yes No		Don't Know
	Yes	No	Know		Yes	No	Know
Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice or liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, indicate type of infection: _____			
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorders. If yes, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion. If yes, date: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Chemotherapy/Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease. If yes, specify below:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders. If yes, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Angina				Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Arteriosclerosis				Persistent swollen glands in neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Artificial heart valves				Respiratory problems. If yes, specify below:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Congenital heart defects				___ Emphysema			
___ Congestive heart failure				___ Bronchitis, etc.			
___ Coronary artery disease				Severe headaches/migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Damaged heart valves				Severe or rapid weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Heart attack				Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain upon exertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disease, drug, or radiation-induced immunosuppression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sores or ulcers in the mouth.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes. If yes, specify below:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Type I (Insulin dependent)				Systemic lupus erythematosus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Type II				Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder. If yes, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells or seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any disease, condition, or problem not listed above that you think I should know about?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Please explain:	_____		
G.E. Reflux/persistent heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		_____		
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		_____		

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: _____

Health History Update: On a regular basis the patient should be questioned about any medical history changes, date and comments notated, along with signature.

Date	Comments	Signature of patient and dentist
_____	_____	_____