

|                |            |                |            |             |       |
|----------------|------------|----------------|------------|-------------|-------|
| Medical Alert: | Condition: | Premedication: | Allergies: | Anesthesia: | Date: |
|----------------|------------|----------------|------------|-------------|-------|

### 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 |   |
|---|--|----|------------|---|
| <p><b>If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.</b></p> <p>Have you had any of the following diseases or problems?</p> <p>Active Tuberculosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Persistent cough greater than a 3 week duration <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Cough that produces blood <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> |  |    |            | Are you taking or have you recently taken any medicine(s) including non-prescription medicine? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
|   |  |    |            | If yes, what medicine(s) are you taking? _____  |
|   |  |    |            | 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? <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"/> |    |            |   |
| If yes, what is/are the condition(s) being treated? _____   | Do you drink alcoholic beverages? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>   |    |            |   |
| Date of last physical examination: _____  | If yes, how much alcohol did you drink in the last 24 hours? _____   |    |            |   |
| Physician: _____  | In the past week? _____  |    |            |   |
| NAME _____ PHONE _____  | Are you alcohol and/or drug dependent? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>  |    |            |   |
| ADDRESS _____ CITY/STATE _____ ZIP _____  | If yes, have you received treatment? (circle one) Yes / No   |    |            |   |
| NAME _____ PHONE _____  | Do you use drugs or other substances for recreational purposes? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>   |    |            |   |
| ADDRESS _____ CITY/STATE _____ ZIP _____  | If yes, please list: _____   |    |            |   |
| Have you had any serious illness, operation, or been hospitalized in the past 5 years? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>   | Frequency of use (daily, weekly, etc.): _____  |    |            |   |
| If yes, what was the illness or problem? _____  | 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               |
|--|--------------------------|--------------------------|--------------------------|
| 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               |
|---|--------------------------|--------------------------|--------------------------|
| 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**

|   | Yes                      | No                       | Don't Know               |
|---|--------------------------|--------------------------|--------------------------|
| 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               |
|---|--------------------------|--------------------------|--------------------------|
| Abnormal bleeding   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS or HIV infection                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatoid arthritis                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood transfusion. If yes, date: _____                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer/ Chemotherapy/Radiation Treatment                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cardiovascular disease. If yes, specify below:            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ___ Angina  |                          |                          |                          |
| ___ Arteriosclerosis                                      |                          |                          |                          |
| ___ Artificial heart valves                               |                          |                          |                          |
| ___ Congenital heart defects                              |                          |                          |                          |
| ___ Coronary artery disease                               |                          |                          |                          |
| ___ Damaged heart valves                                  |                          |                          |                          |
| ___ Heart attack  |                          |                          |                          |
| ___ Chest pain upon exertion                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ___ Chronic pain  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ___ Disease, drug, or radiation-induced immunosuppression | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ___ Diabetes. If yes, specify below:                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ___ Type I (Insulin dependent)                            |                          |                          |                          |
| ___ Type II   |                          |                          |                          |
| ___ Dry Mouth   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ___ Eating disorder. If yes, specify: _____               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ___ Epilepsy  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ___ Fainting spells or seizures                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ___ Gastrointestinal disease                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ___ G.E. Reflux/persistent heartburn                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ___ Glaucoma  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

|   | Yes                      | No                       | Don't Know               |
|---|--------------------------|--------------------------|--------------------------|
| Hemophilia  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis, jaundice or liver disease  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Recurrent Infections  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, indicate type of infection: _____   |                          |                          |                          |
| Kidney problems   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mental health disorders. If yes, specify: _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Malnutrition  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Night sweats  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Neurological disorders. If yes, specify: _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Osteoporosis  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent swollen glands in neck   |                          |                          |                          |
| Respiratory problems. If yes, specify below:  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ___ Emphysema   |                          |                          |                          |
| ___ Bronchitis, etc.  |                          |                          |                          |
| Severe headaches/migraines  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Severe or rapid weight loss   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sexually transmitted disease  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus trouble   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep disorder  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sores or ulcers in the mouth  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Systemic lupus erythematosus  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid problems  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ulcers  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Excessive urination   | <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"/> |
| 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. 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 |
| _____ | _____    | _____                            |