

Health History Form

Name _____ Home Phone(____) _____

Address _____ Last _____ First _____ M _____ City _____ State _____ Zip Code _____

Cell Phone(____) _____ Business Phone(____) _____ E-mail Address _____

Occupation _____ Social Security No. _____ Date of Birth ____/____/____ Sex M F

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

What is the purpose of your current dental visit. _____

Date of your last dental exam. _____ Date of last dental x-rays. _____

Have you had a serious/difficult problem associated with any previous dental treatment? If so, explain.

How do you feel about the appearance of your teeth? _____

Have you ever been diagnosed or treated for oral cancer? Yes No If so, explain.

Medical Information

Yes No

- Are you in good health?
- Has there been any change in your general health within the last year?
- Are you now under the care of a physician? If so what is/are the conditions being treated?

Physician

Name _____ Phone _____ Address _____ City/State/Zip _____

Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, what was the illness or problem? _____

Are you taking or have you recently taken any medicine(s) including non-prescription medicine? If so, what medicine(s) are you taking? Please list: _____

- Do you drink alcoholic beverages? Daily Weekly Monthly Socially
- Are you alcohol and/or drug dependant? If so, have you received treatment? Yes No
- Do you use drugs or other substances for recreational purposes? Please list. _____
- Do you use tobacco (smoking, snuff, chew)? If so, frequency of use. _____

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

- | | | |
|--|---|---|
| Yes No | Yes No | Yes No |
| <input type="checkbox"/> <input type="checkbox"/> Aspirin | <input type="checkbox"/> <input type="checkbox"/> Other antibiotics | <input type="checkbox"/> <input type="checkbox"/> Metals |
| <input type="checkbox"/> <input type="checkbox"/> Penicillin | <input type="checkbox"/> <input type="checkbox"/> Local anesthetics | <input type="checkbox"/> <input type="checkbox"/> Iodine |
| <input type="checkbox"/> <input type="checkbox"/> Erythromycin | <input type="checkbox"/> <input type="checkbox"/> Sedatives | <input type="checkbox"/> <input type="checkbox"/> Hay fever/seasonal |
| <input type="checkbox"/> <input type="checkbox"/> Clindamycin | <input type="checkbox"/> <input type="checkbox"/> Codeine and other narcotics | <input type="checkbox"/> <input type="checkbox"/> Food (Specify) _____ |
| <input type="checkbox"/> <input type="checkbox"/> Sulfa drugs | <input type="checkbox"/> <input type="checkbox"/> Latex | <input type="checkbox"/> <input type="checkbox"/> Other (Specify) _____ |

To yes responses, specify type of reaction _____

Yes No

- Do you have an artificial heart valve, mitral valve prolapse or heart murmur?
- Have you had an orthopedic total joint (hip, knee, elbow) replacement? If so, when was this surgery done? _____
- Has a physician recommended that you take antibiotics prior to your dental treatment? If so, what Antibiotic and dose? _____

Name of physician. _____ Phone _____

Please continue to the next page

Please (X) the appropriate box.

Yes No

- Abnormal bleeding
- Aids or HIV infection
- Anemia
- Asthma
- Bronchitis
- Rheumatoid arthritis
- Cancer/chemotherapy/radiation therapy
Explain: _____
- Cardiovascular Disease
If yes, specify below
 - Angina
 - Arteriosclerosis
 - Artificial heart valves
 - Coronary insufficiency
 - Coronary occlusion
 - Damaged heart valves
 - Heart attack
 - Heart murmur
 - High blood pressure
 - Low blood pressure
 - Congenital heart defects
 - Mitral valve prolapse
 - Pacemaker
 - Defibrillator
 - Rheumatic heart disease

Yes No

- Disease, drug or radiation induced immunosuppression
- Diabetes
- Dry mouth
- Emphysema
- Eating disorder. If yes, specify. _____
- Epilepsy

Yes No

- Seizures or fainting spells
- Gastritis
- Hemophilia
- Hepatitis or liver disease
- Recurrent infections-Indicate type of infection(s):

- Mental health disorders. If yes, specify _____
- Migraines or severe headaches
- Multiple Sclerosis
- Neurological disorders. If yes, specify. _____
- Osteoporosis
- Persistant swollen glands in neck
- Sexually transmitted diseases
- Sinus trouble
- Sleep disorders
- Sores or ulcers in mouth
- Stroke
- Systemic lupus erythmatous
- Thyroid problems
- Tuberculosis
- Ulcers
- Excessive urination
- Do you have any disease, condition or problem that is not listed above? Please explain. _____

(Women Only)

Yes No

- Are you pregnant?
- Nursing?
- Taking birth control pills?

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 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 _____

Signature of Dentist

Date

Health History Updates:

Date

Comments

Signature of dentist

