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

HEALTH HISTORY FORM

Name _____ Home Phone _____ Business Phone _____

Address _____ City _____ State _____ Zip Code _____

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?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Do you have 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 yes, 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
If you answer yes to any of the three items below, please stop and return this form to the receptionist.	☐	☐	☐
Have you had any of the following diseases or problems?			
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐
Are you now under the care of a physician?	☐	☐	☐

If yes, what is/are the condition(s) being treated? _____

_____

Date of last physical examination: _____

Physician: _____
NAME PHONE

_____
ADDRESS CITY/STATE ZIP

_____
NAME PHONE

_____
ADDRESS CITY/STATE ZIP

	Yes	No	Don't Know
Have you had any serious illness, operation, or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem? _____

_____

_____

_____

_____

_____

	Yes	No	Don't Know
Are you taking or have you recently taken any medicine(s) including non-prescription medicine?	☐	☐	☐

If yes, what medicine(s) are you taking?

Prescribed: _____

_____

Over the counter: _____

_____

Vitamins, natural or herbal preparations and/or diet supplements: _____

_____

	Yes	No	Don't Know
Are you taking, or 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 week? _____

	Yes	No	Don't Know
Are you alcohol and/or drug dependent?	☐	☐	☐

If yes, have you received treatment? (circle one) Yes / No

	Yes	No	Don't Know
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: _____

	Yes	No	Don't Know
Do you use tobacco (smoking, snuff, chew)?	☐	☐	☐

If yes, how interested are you in stopping?
(circle one) Very / Somewhat / Not interested

	Yes	No	Don't Know
Do you wear contact lenses?	☐	☐	☐

	Yes	No	Don't Know
Are you allergic to or have you had a reaction to?			
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturayes, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Latex	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food (specify) _____	☐	☐	☐
Other (specify) _____	☐	☐	☐
Metals (specify) _____	☐	☐	☐

To yes responses, specify type of reaction.

_____

_____

_____

_____

	Yes	No	Don't Know
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement)?	☐	☐	☐

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?

_____

_____

	Yes	No	Don't Know
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

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?	☐	☐	☐
Nursing?	☐	☐	☐
Taking birth control pills or hormonal replacement?	☐	☐	☐

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	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Anemia	☐	☐	☐
Arthritis	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Asthma	☐	☐	☐
Blood transfusion. If yes, date: _____	☐	☐	☐
Cancer/Chemotherapy/Radiation Treatment	☐	☐	☐
Cardiovascular disease. If yes, specify below:	☐	☐	☐

___ Angina
___ Arteriosclerosis
___ Artificial heart valves
___ Congenital heart defects
___ Congestive heart failure
___ Coronary artery disease
___ Damaged heart valves
___ Heart attack
___ Heart murmur
___ High blood pressure
___ Low blood pressure
___ Mitral valve prolapse
___ Pacemaker
___ Rheumatic heart disease/Rheumatic fever

Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Disease, drug, or radiation-induced immunosuppression	☐	☐	☐
Diabetes. If yes, specify below:	☐	☐	☐

___ Type I (Insulin dependent) ___ Type II

Dry Mouth	☐	☐	☐
Eating disorder. If yes, specify: _____	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Glaucoma	☐	☐	☐

	Yes	No	Don't Know
Hemophilia	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Recurrent Infections	☐	☐	☐
If yes, Indicate type of infection: _____			
Kidney problems	☐	☐	☐
Mental health disorders. If yes, specify: _____	☐	☐	☐
Malnutrition	☐	☐	☐
Night sweats	☐	☐	☐
Neurological disorders. If yes, specify: _____	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Respiratory problems. If yes, specify below:	☐	☐	☐

___ Emphysema ___ Bronchitis, etc.

Severe headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Sinus trouble	☐	☐	☐
Sleep disorder	☐	☐	☐
Sores or ulcers in the mouth	☐	☐	☐
Stroke	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Tuberculosis	☐	☐	☐
Thyroid problems	☐	☐	☐
Ulcers	☐	☐	☐
Excessive urination	☐	☐	☐

Do you have any disease, condition, or problem Not listed above that you think I should know about?	☐	☐	☐

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 don not take because or 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**
_____	_____	_____
_____	_____	_____