

Medical Alert	Condition	Premedication	Allergies	Anesthesia	Date
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## 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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"/>
Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear removable dental appliances?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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: \_\_\_\_\_

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any of the following diseases or problems?			
Active Tuberculosis	<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"/>
Cough that produces blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has there been any change in your general health within the past years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you now under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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

If yes, what was the illness or problem? \_\_\_\_\_

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

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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you drink alcoholic beverages?  Yes  No  Don't Know

If yes, how much alcohol did you drink in the last 24 hours? \_\_\_\_\_

In the past week? \_\_\_\_\_

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

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

Do you use drugs or other substances for recreational purposes?  Yes  No  Don't Know

If yes, please list: \_\_\_\_\_

Frequency of use (daily, weekly, etc.): \_\_\_\_\_

Number of years of recreational drug use: \_\_\_\_\_

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

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

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

Are you taking any of the following medications for osteoporosis or bone loss due to aging, Paget's Disease, multiple myeloma or any other type of cancer?  Yes  No  Don't Know

If yes, please check the appropriate medication below

Orally Administered Bisphosphonates

<input type="checkbox"/> Alendronate (Fosamax®)	IV Administered Bisphosphonates
<input type="checkbox"/> Etidronate (Didronal® or Didrocal®) or CO Etidronate® or Gen-Etidronate®)	<input type="checkbox"/> Clodronate (Bonelas® or Clasteror® or Ostac®)
<input type="checkbox"/> Ibandronate (Boniva®)	<input type="checkbox"/> Pamidronate (Aredia®)
<input type="checkbox"/> Risedronate (Actonel®)	<input type="checkbox"/> Zoledronic acid (Zometa® or Aclasta®)
<input type="checkbox"/> Tiludronate (Skeldi®)	
<input type="checkbox"/> Other	

	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?			
_____			

	Yes	No	Don't Know
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 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			
___ 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	<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:			
___ 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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 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?  Yes  No  Don't Know

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 can 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
_____	_____	_____
_____	_____	_____