

Health History Form

ADA American Dental Association®

America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that 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.

Name:			Home Phone: <i>Include area code</i>	Business/Cell Phone: <i>Include area code</i>	
<i>Last</i>	<i>First</i>	<i>Middle</i>	()	()	()
Address:			City:	State:	Zip:
<i>Mailing address</i>					
Occupation:			Height:	Weight:	Date of Birth: Sex: M F
SS# or Patient ID:	Emergency Contact:		Relationship:	Home Phone: <i>Include area code</i>	Cell Phone: <i>Include area code</i>
			()	()	()

If you are completing this form for another person, what is your relationship to that person?

Your Name Relationship

Do you have any of the following diseases or problems: (Check DK if you Don't Know the answer to the the question) **Yes No DK**

Active Tuberculosis.....

Persistent cough greater than a 3 week duration.....

Cough that produces blood.....

Been exposed to anyone with tuberculosis.....

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

Yes No DK	Yes No DK
Do your gums bleed when you brush or floss?..... <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"/>
Are your teeth sensitive to cold, hot, sweets or pressure?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your mouth dry?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you brux or grind your teeth?..... <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 have sores or ulcers in your mouth?..... <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"/>	Do you wear dentures or partials?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any problems associated with previous dental treatment?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you participate in active recreational activities?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your home water supply fluoridated?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you drink bottled or filtered water?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of your last dental exam:
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY	What was done at that time?
Are you currently experiencing dental pain or discomfort?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of last dental x-rays:
What is the reason for your dental visit today?	
How do you feel about your smile?	

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

Yes No DK	Yes No DK
Are you now under the care of a physician?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Physician Name: <input type="text"/>	If yes, what was the illness or problem?
Phone: <i>Include area code</i> ()	
Address/City/State/Zip:	Are you taking or have you recently taken any prescription or over the counter medicine(s)?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are you in good health?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:
Has there been any change in your general health within the past year?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>
If yes, what condition is being treated?	<input type="text"/>
Date of last physical exam:	<input type="text"/>

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

(Check DK if you Don't Know the answer to the question) **Yes No DK**

Do you wear contact lenses?

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

Date: _____ If yes, have you had any complications? _____

Do you use tobacco (smoking, snuff, chew, bidis)?

If so, how interested are you in stopping?
Circle one: VERY / SOMEWHAT / NOT INTERESTED

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia®, Boniva®, Reclast®, Prolia®) for osteoporosis or Paget's disease?

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?

Date Treatment began: _____

WOMEN ONLY Are you:

Pregnant?

Number of weeks: _____

Taking birth control pills or hormonal replacement?

Nursing?

Allergies. Are you allergic to or have you had a reaction to: To all **yes** responses, specify type of reaction. **Yes No DK**

Local anesthetics

Aspirin

Penicillin or other antibiotics

Barbiturates, sedatives, or sleeping pills

Sulfa drugs

Codeine or other narcotics

Yes No DK

Metals _____

Latex (rubber) _____

Iodine _____

Hay fever/seasonal _____

Animals _____

Food _____

Other _____

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

		Yes No DK			Yes No DK			Yes No DK
Artificial (prosthetic) heart valve		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Autoimmune disease		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Glaucoma		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Previous infective endocarditis		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rheumatoid arthritis		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hepatitis, jaundice or liver disease		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Damaged valves in transplanted heart		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Systemic lupus erythematosus		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Epilepsy		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Congenital heart disease (CHD)			Asthma		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Fainting spells or seizures		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Unrepaired, cyanotic CHD		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Bronchitis		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Neurological disorders		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Repaired (completely) in last 6 months		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Emphysema		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If yes, specify: _____		
Repaired CHD with residual defects		<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"/>
<i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i>			Tuberculosis		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you snore?		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	Yes No DK		Cancer/Chemotherapy/ Radiation Treatment		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Mental health disorders		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cardiovascular disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Mitral valve prolapse		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Chest pain upon exertion		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Specify: _____
Angina	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Pacemaker		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Chronic pain		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Recurrent Infections
Arteriosclerosis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rheumatic fever		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Diabetes Type I or II		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Type of infection: _____
Congestive heart failure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rheumatic heart disease		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Eating disorder		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Kidney problems
Damaged heart valves	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Abnormal bleeding		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Malnutrition		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Night sweats
Heart attack	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Anemia		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Gastrointestinal disease		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Osteoporosis
Heart murmur	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Blood transfusion		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	G.E. Reflux/persistent heartburn		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Persistent swollen glands in neck
Low blood pressure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If yes, date: _____		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Ulcers		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Severe headaches/migraines
High blood pressure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hemophilia		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Thyroid problems		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Severe or rapid weight loss
Other congenital heart defects	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	AIDS or HIV infection		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Stroke		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sexually transmitted disease
		Arthritis		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Excessive urination

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

Name of physician or dentist making recommendation: _____ Phone: *Include area code* ()

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 and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. 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: _____

Signature of Dentist: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____
