Health History Form

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.

Patient Name: DOB:

Last First M. Init. Preferred:

Dental Information:

Please circle your responses to the following questions (Y = Yes, N = No, DK = Don't Know.)

- Do your gums bleed when you brush or floss?....... Y N DK
- Are your teeth sensitive to cold, hot, sweets, or pressure?....... Y N DK
- Does food catch between your teeth?....... Y N DK
- Is your mouth dry?....... Y N DK
- Have you had any periodontal (gum) treatments?....... Y N DK
- Have you ever had orthodontic (braces) treatment?....... Y N DK
- Have you had any problems associated with previous dental treatment?....... Y N DK
- Do you drink bottled or filtered water? Y N DK
  If yes, how often? DAILY/WEEKLY/OCCASIONALLY
- Are you currently experiencing dental pain or discomfort?....... Y N DK
- Do you have earaches or neck pains?....... Y N DK
- Do you have any clicking, popping, or discomfort in the jaw?....... Y N DK
- Do you clench or grind your teeth?....... Y N DK
- Do you have sores or ulcers in your mouth?....... Y N DK
- Do you wear dentures or partials?....... Y N DK
- Do you participate in active recreational activities?....... Y N DK
- Have you ever had a serious injury to your head or mouth?....... Y N DK

Date of your last dental exam: What was done at that time?

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 circle your responses to the following questions (Y = Yes, N = No, DK = Don't Know.)

- Are you now under the care of a physician?....... Y N DK
  Physician Name: Phone: ( )
  Address/City/State/Zip:
- Are you in good health?....... Y N DK
- Has there been any change in your general health within the past year?....... Y N DK
  If yes, what condition is being treated?
- Date of last physical exam:
- Have you had a serious illness, operation, or been hospitalized in the past 5 years?....... Y N DK
  If yes, what was the illness or problem?
- Are you taking or have you recently taken any prescription or over-the-counter medicines?....... Y N DK
  If so, please list all medications, vitamins, and/or natural/herbal/dietary supplements:
  ____
  ____
  ____
  ____

Allergies – are you allergic to or have had a reaction to any of the following:

___ Local anesthetics	___ Aspirin	___ Penicillin or other antibiotics	___ Sulfa drugs
___ Barbituates, sedatives, or sleeping pills	___ Codeine or other narcotics	___ Metals	___ Latex (rubber)
___ Iodine	___ Hay fever/seasonal	___ Animals	___ Food
___ Other (please list):			

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- Joint replacement – Have you had an orthopedic complete joint (hip, knee, elbow, finger) replacement?................................ Y N DK
- Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risendronate (Actonel) for osteoporosis or Paget's disease?.. Y N DK
- Have you been treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer?.. Y N DK
- Do you use controlled substances (drugs)?.. Y N DK
- Do you use tobacco (smoking, snuff, chew)?.. Y N DK
  If so, how interested are you in stopping?
  (Circle one) VERY / SOMEWHAT / NOT INTERESTED
- Do you drink alcoholic beverages?.. Y N DK
  If yes, how much alcohol did your drink in the last 24 hours?
  If yes, how much do you typically drink in a week?

WOMEN ONLY: Are you:

- Pregnant?.. Y N DK
- Taking birth control pills or hormonal replacement?.. Y N DK
- Nursing?.. Y N DK

Please mark (X) if you have or ever have had any of the following diseases or problems:

___	Artificial heart valve	___	Other congenital heart defects	___	Emphysema	___	Hepatitis, jaundice, or liver disease
___	Infective endocarditis	___	Mitral valve prolapse	___	Sinus trouble	___	Epilepsy
___	Damaged valves in transplanted heart	___	Pacemaker	___	Tuberculosis	___	Fainting spells or seizures
___	Congenital heart disease (CHD)	___	Rheumatic fever	___	Cancer/ chemotherapy/ radiation treatment	___	Neurological disorders Specify:___________
___	Unrepaired cyanotic CHD	___	Rheumatic heart disease	___	Chest pain upon exertion	___	Sleep disorder
___	Repaired (completely) in the last 6 months	___	Abnormal bleeding	___	Chronic pain	___	Mental health disorder Specify:___________
___	Repaired CHD with residual defects	___	Anemia	___	Diabetes Type I or Type II	___	Recurrent infections
___	Cardiovascular disease	___	Blood transfusion Date:___________	___	Eating disorder	___	Kidney problems
___	Angina	___	Hemophelia	___	Malnutrition	___	Night sweats
___	Arteriosclerosis	___	AIDS or HIV infection	___	Gastrointestinal disease	___	Osteoporosis
___	Congestive heart failure	___	Arthritis	___	GE Reflux/persistent heart burn	___	Persistent swollen glands in neck
___	Damaged heart valves	___	Autoimmune disease	___	Ulcers	___	Severe headaches/migraines
___	Heart attack	___	Rheumatoid arthritis	___	Thyroid problems	___	Severe or rapid weight loss
___	Heart murmur	___	Systemic lupus erythematosus	___	Stroke	___	Sexually Transmitted Disease
___	Low blood pressure	___	Asthma	___	Glaucoma	___	Excessive urination
___	High blood pressure	___	Bronchitis				

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

Do you have any disease, condition, or problem not listed above that you think I should know about?.. Y N DK

Please explain:

Note: Both Doctor and patients 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 staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member or 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: