Health History

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: _____ DOB: _____ SS# _____
Gender: M / F Height: _____ Weight: _____ Occupation: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone (include area code):_____ Cell: _____ E-Mail:_____
Emergency Contact: _____ Relationship: _____ Phone:_____

If you are completing this 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 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 questions above, please stop and return this form to the receptionist.)

Dental Information (Please mark your response to the following questions.)

	Yes	**No**	**DK**
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated w/previous dental work?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do your drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing any dental pain/discomfort?	☐	☐	☐
What is the reason for your visit today? _____			

	Yes	**No**	**DK**
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping, or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores/ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐
Date of your last dental exam: _____			
What was done at that time? _____			
Date of last dental x-rays? _____			
How do you feel about your smile? _____			
Are you interested in whitening?	☐	☐	☐

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

	Yes	**No**	**DK**
Are you under the care of a physician?	☐	☐	☐
Physician Name: _____ Phone:_____			
Address: _____			
Are you in good health?	☐	☐	☐
Has there been any change in your health within the past year?	☐	☐	☐
If yes, what condition is being treated? _____			
_____			
Date of last physical exam: _____			
Do you take **aspirin** or a prescribed blood thinner?	☐	☐	☐
If yes, what? _____			

	Yes	**No**	**DK**
Have you had a serious illness, operation or been hospitalized?	☐	☐	☐
If yes, what was the illness/problem and when? _____			
_____			
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐
If so, please list **ALL**, including vitamins, natural or herbal preparations and/or diet supplements: _____			
_____			
_____			
_____			

Medical Information (Please mark your responses to indicate if you don't know (DK), have or have not had any of the following diseases or problems.)

	Yes	No	DK
Have you ever had any type of Augmentation?	□	□	□
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger, etc.) replacement?	□	□	□
Date: _____ Surgeon: _____			
Are you taking or scheduled to begin taking either of the medications, Fosamax, Boniva or Actonel for osteoporosis for Paget's disease?	□	□	□
Since 2001, were you 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?	□	□	□
Date treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	□	□	□
Do you use tobacco (smoking, snuff, chew)?	□	□	□
If so, how interested are you in stopping? (circle one.) VERY SOMEWHAT NOT INTERESTED			
Do you drink alcoholic beverages?	□	□	□
If yes, how much have you had in the las 24 hrs.? _____			
If yes, how much do you typically drink in a week? _____			

WOMEN ONLY – Are you:

Pregnant?	□	□	□
Number of weeks: _____			
Taking birth control pills or hormonal replacements?	□	□	□
Nursing?	□	□	□
Breast Augmentation?	□	□	□

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 _____	□	□	□
Penicillin or other antibiotics _____	□	□	□
Aspirin _____	□	□	□
Barbituates, sedatives or sleeping pills _____	□	□	□
Sulfa Drugs _____	□	□	□
Codeine or other narcotics _____	□	□	□

	Yes	No	DK
Metals _____	□	□	□
Latex _____	□	□	□
Iodine _____	□	□	□
Hay fever/seasonal _____	□	□	□
Animals _____	□	□	□
Other _____	□	□	□

(Please mark your responses to indicate if you don't know (DK), have or have not had any of the following diseases or problems.)

	Yes	No	DK
Artificial Heart Valve	□	□	□
Damaged valves in transplanted heart	□	□	□
Unrepaired, cyanotic (CHD)	□	□	□
Repaired CHD w/residual defects	□	□	□
Previous Infective endocarditis	□	□	□
Congenital heart disease (CHD)	□	□	□
Repaired (completely) CHD	□	□	□

***Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.**

Cardiovascular Disease	□	□	□
Angina	□	□	□
Arteriosclerosis	□	□	□
Congestive heart failure	□	□	□
Damaged heart valves	□	□	□
Heart Attack	□	□	□
Heart murmur	□	□	□
Low blood pressure	□	□	□
High blood pressure	□	□	□
Other congenital heart defects	□	□	□
Mitral Valve Prolapse	□	□	□
Pacemaker	□	□	□
Rheumatic fever	□	□	□
Rheumatic heart disease	□	□	□
Abnormal bleeding	□	□	□
Anemia	□	□	□
Hemophilia	□	□	□
Arthritis	□	□	□
Glaucoma	□	□	□
Excessive urination	□	□	□

Blood Transfusion	□	□	□
If yes, date: _____			
AIDS or HIV infection	□	□	□
Autoimmune disease	□	□	□
Rheumatoid arthritis	□	□	□
Systemic lupus erythematosus	□	□	□
Asthma	□	□	□
Bronchitis	□	□	□
Emphysema	□	□	□
Sinus trouble	□	□	□
Tuberculosis	□	□	□
Cancer/Chemo/Radiation	□	□	□
Chest Pain upon exertion	□	□	□
Chronic pain	□	□	□
Diabetes Type I or II	□	□	□
Eating disorder	□	□	□
Malnutrition	□	□	□
Gastrointestinal disease	□	□	□
G.E. reflux/Heart Burn	□	□	□
Severe or rapid weight loss	□	□	□

Ulcers	□	□	□
Thyroid problems	□	□	□
Stroke	□	□	□
Hepatitis A, B, or C	□	□	□
Epilepsy	□	□	□
Fainting spells or seizures	□	□	□
Neurological disorders	□	□	□
If yes, specify: _____			
Sleep disorder	□	□	□
Mental health disorders	□	□	□
Specify: _____			
Recurrent infections	□	□	□
Type: _____			
Kidney problems	□	□	□
Night sweats	□	□	□
Osteoporosis/Osteopenia	□	□	□
Persistent swollen glands (neck)	□	□	□
Severe headaches/migraines	□	□	□
Sexually transmitted disease	□	□	□

Do you have any disease, condition, or problem not listed above that you think we should know about? □ □ □

Please explain: _____

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

Name of physician or dentist making recommendation: _____ Phone: _____

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 question, 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.

✖ _____ **Date:** _____

Patient, Parent or Guardian Signature