Health History Form

Name: _____ Date: _____

DENTAL INFORMATION

YES	NO	DON'T KNOW		YES	NO	DON'T KNOW	
☐	☐	☐	Do your gums bleed when you brush?	☐	☐	☐	Have you ever had orthodontic treatment?
☐	☐	☐	Are your teeth sensitive to cold, hot, sweets, or pressure	☐	☐	☐	Do you have headaches, earaches or neck pains?
☐	☐	☐	Have you had any serious/difficult problem associated with any previous dental treatment? If so, explain _____				

How would you describe your current dental problem? _____

Date of your last dental exam _____ Date of last hygiene appt _____ Name of last dentist _____

What was done at that time? _____ Date of last dental x-rays _____

How do you feel about the appearance of your teeth? _____ Do you have any problems with bad breath? _____

MEDICAL INFORMATION

YES	NO	DON'T KNOW	
☐	☐	☐	Are you in good health?
☐	☐	☐	Has there been any changes in your health within the past year?
☐	☐	☐	Are you under the care of a physician? If so, what are the conditions being treated? _____

_____ Date of last exam _____

Physician(s) _____

Name Phone Address City/State/Zip

_____

Name Phone Address City/State/Zip

☐ ☐ ☐ Have you ever had any serious illness, operation, or been hospitalized in the past five years? If so, what was the illness or problem? _____

☐ ☐ ☐ Do you drink soft drinks / sports drinks? If yes how many per day? _____

☐ ☐ ☐ Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the past week? _____ month? _____
If yes, _____ # drinks per day for _____ # of years

☐ ☐ ☐ Are you alcohol and/or drug dependent? If so have you received treatment? (check one) ☐ YES ☐ NO

☐ ☐ ☐ Do you use drugs or other substances for recreational purposes? If yes, please list _____

☐ ☐ ☐ Do you use tobacco (smoking or chew)? If so, how interested are you in quitting? ☐ Very ☐ Somewhat ☐ Not at all

☐ ☐ ☐ How many years have or did you use tobacco? _____ How much tobacco did you use per day? _____

Are you taking any medications? If yes, for what purposes? PLEASE LIST BELOW

NAME OF DRUG	PURPOSE	DATE

Are you allergic or have you had a reaction to;

YES	NO	DON'T KNOW	
☐	☐	☐	Local Anesthetics
☐	☐	☐	Penicillin or other antibitoics
☐	☐	☐	Barbiturates, sedatives, or sleeping pills
☐	☐	☐	Codeine or other narcotics
☐	☐	☐	Latex
☐	☐	☐	Iodine
☐	☐	☐	Hay fever/seasonal
☐	☐	☐	Metal

Other (specify) _____

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
- ☐ ☐ ☐ AIDS or HIV
- ☐ ☐ ☐ Anemia
- ☐ ☐ ☐ Arthritis
- ☐ ☐ ☐ Rheumatoid Arthritis
- ☐ ☐ ☐ Asthma
- ☐ ☐ ☐ Blood transfusion If yes, Date:_____
- ☐ ☐ ☐ Cancer/Chemotherapy/Radiation
- ☐ ☐ ☐ Cardiovascular diseases? If yes, please specify
  - _____ Angina Pectoris
  - _____ Heart murmur
  - _____ Bypass Sugery
  - _____ Mitral Valve Prolapse
  - _____ Pacemaker
  - _____ Rheumatic fever
  - _____ Artificial valves
  - _____ Heart attack – Date: _____
  - _____ High Blood Pressure
- ☐ ☐ ☐ Chest Pain upon exertion
- ☐ ☐ ☐ Chronic Pain
- ☐ ☐ ☐ Disease, drug, or radiation-induced immunosuppression
- ☐ ☐ ☐ Diabetes. If yes, please specifiy
  _____ Type 1 (insulin dependent) _____ Type II
- ☐ ☐ ☐ Dry mouth
- ☐ ☐ ☐ Eating disorder. If yes, please 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
- ☐ ☐ ☐ Reccurent Infection
  If yes, indicate type of infection _____
- ☐ ☐ ☐ Mental Health disorder
- ☐ ☐ ☐ Night Sweats
- ☐ ☐ ☐ Neurological disorders
- ☐ ☐ ☐ Osteoporosis
- ☐ ☐ ☐ Persistant swollen glands
- ☐ ☐ ☐ Respiratory problems. If yes, please specify:
  ____ Emphysema ____ Bronchitis, etc.
- ☐ ☐ ☐ Severe headaches/migraines
- ☐ ☐ ☐ Severe or rapid weight loss
- ☐ ☐ ☐ Sexually transmitted Disease
- ☐ ☐ ☐ Sinus Trouble
- ☐ ☐ ☐ Sores or ulcers in the mouth
- ☐ ☐ ☐ Stroke. If yes, Date:_____
- ☐ ☐ ☐ Systemic Lupus Erythematosus
- ☐ ☐ ☐ Tuberculosis
- ☐ ☐ ☐ Thyroid problems
- ☐ ☐ ☐ Ulcers
- ☐ ☐ ☐ Excessive urination
- ☐ ☐ ☐ Joint Replacement
- ☐ ☐ ☐ Do you have any disease not listed above that you think we should know about?
  Please Explain: _____
  _____
- ☐ ☐ ☐ Have you ever been told you needed to premedicate before your dental appointment

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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 because of errors or ommission that I may have made in the completion of this form.

_____ _____

SIGNATURE OF PATIENT/LEGAL GUARDIAN DATE

Date	Comments/Changes	Signature of patient	Signature of Dentist