HEALTH HISTORY FORM

Name: First | Preferred (if different) | Middle Initial | Last | Referral source

Address: Street | City | State | Zip Code | Date of Birth

Sex: M or F

SS# | Mobile Phone | Home Phone | E-mail address

Emergency Contact name | Relationship | Phone | If you are completing this form for another person, what is your relationship to that person? | Name

Employer | For billing purposes, are any of your immediate family members currently patients with us? If so, please list their name(s) above.

DENTAL INFORMATION

	Yes	No	Don't Know
Do your gums bleed when you brush?			
Have you ever had previous ortho (braces) treatment?			
Are your teeth sensitive to cold/hot/sweets/pressure?			
Do you have earaches or neck pains?			
Have you had any periodontal (gum) treatments?			
Do you wear removable dental appliances?			
Have you had any serious/negative dental experiences?			
If yes, explain:			
Have you/do you experience (d) dental anxiety?			

	Yes	No	Don't Know
Do you have any current dental concerns?			

If yes, explain:

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

Have you had any of the following diseases or problems?	Yes	No	Don't Know
Active Tuberculosis			
Persistant cough lasting greater than 3 weeks			
Cough that produces blood			
Are you in good health?			
Are you currently under the care of a physician or specialist?			

Physician Name: Phone:

Speciality:

Phone:

Location:

What is this physician treating you for?

Physician Name: Phone:

Speciality:

Phone:

Location:

What is this physician treating you for?

Physician Name: Phone:

Speciality:

Phone:

Location:

What is this physician treating you for?

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

Prescribed:

Current medications (continued)

Over the counter:

Vitamins, natural, or herbal preparations and/or diet supplements:

	Yes	No	Don't Know
Are you taking, or have you taken and diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?			
Do you drink alcoholic beverages?			

If yes, how much alcohol have you consumed in the past 24 hrs?

In the past week?

Are you alcohol or drug dependent?			
If yes, have you received treatment?			
Do you use drugs or substances for recreational purposes?			

If yes, please list:

Frequency of use (daily/weekly/etc):

Number of years of recreational drug use:

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

If yes, how interested are you in stopping? Very / Somewhat / Not interested

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

Are you allergic, or have you had a reaction to:

Local anesthetics			
Aspirin			

**** Please complete both pages ****

Allergies, continued

	Yes	No	Don't Know
Penicillin or other antibiotics			
Barbiturates, sedatives, or sleeping pills			
Sulfa drugs			
Codeine or other narcotics			
Latex			
Iodine			
Food (specify) _____			
Metals (specify) _____			
Other (specify) _____			

To yes responses, specify type of reaction:

	Yes	No	Don't Know
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?			

If yes, when was the operation done?

	Yes	No	Don't Know
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?			

If yes, what antibiotic and dose?

Name of physician or dentist:

Phone:

Have you had any of the following diseases or problems?	Yes	No	Don't Know
Abnormal Bleeding			
AIDS or HIV infection			
Anemia			
Rheumatoid arthritis			
Asthma			
Blood transfusion (If yes, date: _____)			
Cancer/Chemotherapy/Radiation Treatment			

Cardiovascular disease

	Yes	No	Don't Know
Angina			
Arteriosclerosis			
Artificial heart valves			
Congenital heart defects			
Congestive heart failure			
Coronary artery disease			
Damaged heart valves			
Heart attack			
Heart murmur			
High blood pressure			

Cardiovascular disease, continued

	Yes	No	Don't Know
Low blood pressure			
Mitral valve prolapse			
Pacemaker			
Rheumatic heart disease/Rheumatic fever			
Chest pain upon exertion			
Chronic pain			
Diabetes (If yes: Type I _____ Type II_____)			
Dry mouth			
Eating disorder (If yes, specify: _____)			
Epilepsy			
Fainting spells or seizures			
Gastroinstestinal disease			
G.E. Reflux/persistent heartburn			
Glaucoma			
Hemophilia			
Hepatitis			
Jaundice or liver disease			
Recurrent infections (If yes, specify: _____)			
Kidney problems			
Mental health disorders (Specify: _____)			
Malnutrition			
Night sweats			
Neurological disorders (Specify: _____)			
Osteoporosis			
Persistent swollen glands in neck			
Respiratory problems (Specify: _____)			
Severe or rapid weight loss			
Sexually transmitted disease			
Sinus trouble			
Sleep disorder			
Sores or ulcers in mouth			
Stroke			
Systemic lupus in the mouth			
Tuberculosis			
Thyroid problems			
Ulcers			
Excessive urination			

Do you have any other disease, condition, or problem not listed above that we should know about? Please explain:

WOMEN ONLY	Yes	No	Don't Know
Are you or could you be pregnant?			
Nursing?			
Taking birth control pills or hormonal replacement?			

NOTE: Both the Doctor and patient are encourage to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understood the above. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfation. 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 ommissions that I may have made in the completion of this form.

Patient signature: **Date:**

Dentist signature: **Date:**