

Health History Form



American Dental Association
www.ada.org

E-mail:

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>	
LastFirstMiddle			()		()	
Address:			City:		State: Zip:	
Mailing address						
Occupation:			Height: Weight:		Date of birth: Sex: M F	
SS# or Patient ID:			Emergency Contact:		Relationship: Home Phone: Cell Phone:	
					() () <i>Include area codes</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 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?	☐	☐	☐	Do you have earaches or neck pains?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐	Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐	Do you brux or grind your teeth?	☐	☐	☐
Is your mouth dry?.....	☐	☐	☐	Do you have sores or ulcers in your mouth?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐	Do you wear dentures or partials?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐	Do you participate in active recreational activities?	☐	☐	☐
Have you had any problems associated with previous dental treatment?.....	☐	☐	☐	Have you ever had a serious injury to your head or mouth?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐	Date of your last dental exam:			
Do you drink bottled or filtered water?	☐	☐	☐	What was done at that time?			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY				Date of last dental x-rays:			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐				
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?	☐	☐	☐	Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐
Physician Name: Phone: <i>Include area code</i>				If yes, what was the illness or problem?			
()							
Address/City/State/Zip:							
Are you in good health?				Are you taking or have you recently taken any prescription or over the counter medicine(s)?			
☐ ☐ ☐				☐ ☐ ☐			
Has there been any change in your general health within the past year?				If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:			
☐ ☐ ☐				_____			
If yes, what condition is being treated?				_____			

Date of last physical exam:				_____			

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		Yes	No	DK								
Do you wear contact lenses?	☐	☐	☐		Do you use controlled substances (drugs)?	☐	☐	☐							
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?	☐	☐	☐		Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐							
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐		If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED										
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?	☐	☐	☐		Do you drink alcoholic beverages?	☐	☐	☐							
Date Treatment began:					If yes, how much alcohol did you drink in the last 24 hours?										
					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 replacement?	☐	☐	☐							
					Nursing?	☐	☐	☐							
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?															
Date: If yes, have you had any complications?															
Allergies - Are you allergic to or have you had a reaction to:															
To all yes responses, specify type of reaction.															
Local anesthetics	☐	☐	☐	Metals	☐	☐	☐								
Aspirin	☐	☐	☐	Latex (rubber)	☐	☐	☐								
Penicillin or other antibiotics	☐	☐	☐	Iodine	☐	☐	☐								
Barbiturates, sedatives, or sleeping pills	☐	☐	☐	Hay fever/seasonal	☐	☐	☐								
Sulfa drugs	☐	☐	☐	Animals	☐	☐	☐								
Codeine or other narcotics	☐	☐	☐	Food	☐	☐	☐								
				Other	☐	☐	☐								
<i>Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.</i>															
Yes No DK	Yes No DK	Yes No DK	Yes No DK	Yes No DK	Yes No DK	Yes No DK	Yes No DK								
Heart murmur.....	☐	☐	☐	Anemia.....	☐	☐	☐	Chronic pain.....	☐	☐	☐	Sleep disorder.....	☐	☐	☐
Mitral valve prolapse.....	☐	☐	☐	Blood transfusion	☐	☐	☐	Diabetes Type I or II.....	☐	☐	☐	Mental health disorders.....	☐	☐	☐
Artificial heart valves	☐	☐	☐	If yes, date:				Eating disorder	☐	☐	☐	Specify:			
Rheumatic fever	☐	☐	☐	Hemophilia	☐	☐	☐	Malnutrition	☐	☐	☐	Recurrent Infections.....	☐	☐	☐
Cardiovascular disease.	☐	☐	☐	AIDS or HIV infection	☐	☐	☐	Gastrointestinal disease	☐	☐	☐	Type of infection:			
Angina	☐	☐	☐	Arthritis	☐	☐	☐	G.E. Reflux/persistent				Kidney problems.....	☐	☐	☐
Arteriosclerosis	☐	☐	☐	Autoimmune disease	☐	☐	☐	heartburn	☐	☐	☐	Night sweats	☐	☐	☐
Congestive heart failure	☐	☐	☐	Rheumatoid arthritis	☐	☐	☐	Ulcers	☐	☐	☐	Osteoporosis.....	☐	☐	☐
Coronary artery disease.....	☐	☐	☐	Systemic lupus				Thyroid problems.....	☐	☐	☐	Persistent swollen glands			
Damaged heart valves.....	☐	☐	☐	erythematosus.....	☐	☐	☐	Stroke.....	☐	☐	☐	in neck.....	☐	☐	☐
Heart attack.....	☐	☐	☐	Asthma.....	☐	☐	☐	Glaucoma	☐	☐	☐	Severe headaches/ migraines.....	☐	☐	☐
Low blood pressure	☐	☐	☐	Bronchitis.....	☐	☐	☐	Hepatitis, jaundice or				Severe or rapid weight loss..	☐	☐	☐
High blood pressure.....	☐	☐	☐	Emphysema	☐	☐	☐	liver disease.....	☐	☐	☐	Sexually transmitted disease.	☐	☐	☐
Congenital heart defects....	☐	☐	☐	Sinus trouble.....	☐	☐	☐	Epilepsy	☐	☐	☐	Excessive urination.....	☐	☐	☐
Pacemaker	☐	☐	☐	Tuberculosis	☐	☐	☐	Fainting spells or seizures ...	☐	☐	☐				
Rheumatic heart disease.....	☐	☐	☐	Cancer/Chemotherapy/ Radiation Treatment.....	☐	☐	☐	Neurological disorders	☐	☐	☐				
Abnormal bleeding	☐	☐	☐	Chest pain upon exertion ...	☐	☐	☐	If yes, Specify:							
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?															
Name of physician or dentist making recommendation:												Phone:			
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:

FOR COMPLETION BY DENTIST

Comments:

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