Health History Form

ADA American Dental Association
American's leading advocate for oral health

Name _____
Last Name First Name Middle Initial

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.

Home Phone: (____) _____ Cell Phone: (____) _____
Email: _____ Can we contact you by email Yes ☐ No ☐ Can we text you Yes ☐ No ☐
What is the best way to contact you. Please check all that applies. ☐ Home Phone # ☐ Cell Phone # ☐ Text ☐ Email ☐ Work Phone #
Address: (mailing address) _____
Occupation: _____ SS# _____ Date of birth: _____ Sex: M F
Emergency Contact: _____ Relationship: _____
Emergency Home Phone: _____ Emergency Cell Phone: _____
Whom may we thank for referring you? _____
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	**Yes**
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 check (✓) if your answer is "yes"

	YES		YES
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?	☐		
Do you drink bottled or filtered water?	☐		
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐		

NEW PATIENTS ONLY

Name of previous dentist _____
Date of last dental x-rays and exam _____
Reason for today's visit _____
Would you like to change anything in your smile Yes ☐ No ☐
Please describe _____

MEDICAL INFORMATION *check (✓) if you have or have had any of the following diseases or problems.*

Physician's Name: _____
Phone: (____) _____
Address/City/State/Zip: _____
_____
Has there been any change in your general health within the past year? Yes ☐
If yes, what condition is being treated? _____
Pharmacy Name and Town: _____
Date of last physical exam: _____

Have you had a serious illness, operation or been hospitalized in the last 5 years? Yes ☐
If yes, what was the illness or problem? _____
_____
Are you taking or have you recently taken any prescription or over the counter medicine(s)? Yes ☐
If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:
_____
_____
_____

MEDICAL INFORMATION *check (✓) if you have or have had any of the following diseases or problems.*

Do you wear contact lenses? ☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐
Date:_____ If yes, have you had any complications? _____

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or 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 complication resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐
Date Treatment began: _____

Do you use controlled substances (drugs)? ☐
Do you use tobacco (smoking, snuff, chew, bidis)? ☐
If so, how interested are you in stopping?
(circle one) VERY / SOMEWHAT / NOT INTERESTED
Do you drink alcohol beverages? ☐
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? ☐

ALLERGIES - Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

Local anesthetics _____ ☐
Aspirin _____ ☐
Penicillin or other antibiotics _____ ☐
Barbiturates, sedatives, or sleeping pills _____ ☐
Sulfa drugs _____ ☐
Codeine or narcotics _____ ☐

Metals ☐
Latex (rubber) ☐
Iodine ☐
Hay fever/seasonal ☐
Animals ☐
Food ☐
Other _____

Please check (✓) if you have or have had any of the following diseases or problems.

Artificial (prosthetic) heart valve ☐
Previous infective endocarditis ☐
Damaged valves in transplanted heart ☐
Congenital heart disease (CHD) ☐
- Unrepaired, cyanotic CHD ☐
- Repaired (completely) in last 6 months ☐
- Repaired CHD with residual defects ☐

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 ☐
Blood transfusion
If yes, date: _____
Hemophilia ☐
AIDS or HIV infection ☐
Arthritis ☐

Autoimmune disease ☐
Rheumatic arthritis ☐
Systemic lupus erythematosus ☐
Asthma ☐
Bronchitis ☐
Emphysema ☐
Sinus trouble ☐
Tuberculosis ☐
Cancer/Chemotherapy/ Radiation Treatment ☐
Chest pain upon exertion ☐
Chronic pain ☐
Diabetes Type I or II ☐
Eating disorder ☐
Malnutrition ☐
Gastrointestinal disease ☐
G.E. Reflux/persistent heartburn ☐
Ulcers ☐
Thyroid problems ☐
Stroke ☐

Glaucoma ☐
Hepatitis, jaundice or liver disease ☐
Epilepsy ☐
Fainting spells or seizures ☐
Neurological disorders
If yes, specify: _____
Sleep disorder ☐
Mental health disorders
Specify: _____
Recurrent infections
Type of infection _____
Kidney problems ☐
Night sweats ☐
Osteoporosis ☐
Persistent swollen glands in neck ☐
Severe headaches/migraines ☐
Severe or rapid weight loss ☐
Sexually transmitted disease ☐
Excessive urination ☐

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: _____

MEDICAL HISTORY UPDATES (FOR COMPLETION BY DENTIST OR HYGIENIST)

DATE:	UPDATES	DATE:	UPDATES	DATE:	UPDATES