

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: *Include area code* _____ Business/Cell Phone: *Include area code* _____
Last First Middle
 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: _____
() () () ()
Include area codes

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does food or floss catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam:			
Do you drink bottled or filtered water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking or have you recently taken any prescription or over the counter medicine(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has there been any change in your general health within the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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:				_____			

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)

Do you wear contact lenses? Yes No DK

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Yes No DK

Date: _____ If yes, have you had any complications? Yes No DK

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? Yes No DK

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? Yes No DK

Date Treatment began: _____

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

Local anesthetics Yes No DK

Aspirin Yes No DK

Penicillin or other antibiotics Yes No DK

Barbiturates, sedatives, or sleeping pills Yes No DK

Sulfa drugs Yes No DK

Codeine or other narcotics Yes No DK

Do you use controlled substances (drugs)? Yes No DK

Do you use tobacco (smoking, snuff, chew, bidis)? Yes No DK

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

Do you drink alcoholic beverages? Yes No DK

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? Yes No DK

Number of weeks: _____

Taking birth control pills or hormonal replacement? Yes No DK

Nursing? Yes No DK

Metals Yes No DK

Latex (rubber) Yes No DK

Iodine Yes No DK

Hay fever/seasonal Yes No DK

Animals Yes No DK

Food Yes No DK

Other Yes No DK

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

Artificial (prosthetic) heart valve Yes No DK

Previous infective endocarditis Yes No DK

Damaged valves in transplanted heart Yes No DK

Congenital heart disease (CHD)

Unrepaired, cyanotic CHD Yes No DK

Repaired (completely) in last 6 months Yes No DK

Repaired CHD with residual defects Yes No DK

Autoimmune disease Yes No DK

Rheumatoid arthritis Yes No DK

Systemic lupus erythematosus Yes No DK

Asthma Yes No DK

Bronchitis Yes No DK

Emphysema Yes No DK

Sinus trouble Yes No DK

Tuberculosis Yes No DK

Cancer/Chemotherapy/ Radiation Treatment Yes No DK

Chest pain upon exertion Yes No DK

Chronic pain Yes No DK

Diabetes Type I or II Yes No DK

Eating disorder Yes No DK

Malnutrition Yes No DK

Gastrointestinal disease Yes No DK

G.E. Reflux/persistent heartburn Yes No DK

Ulcers Yes No DK

Thyroid problems Yes No DK

Stroke Yes No DK

Glaucoma Yes No DK

Hepatitis, jaundice or liver disease Yes No DK

Epilepsy Yes No DK

Fainting spells or seizures Yes No DK

Neurological disorders Yes No DK

If yes, specify: _____

Sleep disorder Yes No DK

Mental health disorders Yes No DK

Specify: _____

Recurrent Infections Yes No DK

Type of infection: _____

Kidney problems Yes No DK

Night sweats Yes No DK

Osteoporosis Yes No DK

Persistent swollen glands in neck Yes No DK

Severe headaches/migraines Yes No DK

Severe or rapid weight loss Yes No DK

Sexually transmitted disease Yes No DK

Excessive urination Yes No DK

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

Cardiovascular disease Yes No DK

Angina Yes No DK

Arteriosclerosis Yes No DK

Congestive heart failure Yes No DK

Damaged heart valves Yes No DK

Heart attack Yes No DK

Heart murmur Yes No DK

Low blood pressure Yes No DK

High blood pressure Yes No DK

Other congenital heart defects Yes No DK

Mitral valve prolapse Yes No DK

Pacemaker Yes No DK

Rheumatic fever Yes No DK

Rheumatic heart disease Yes No DK

Abnormal bleeding Yes No DK

Anemia Yes No DK

Blood transfusion Yes No DK

If yes, date: _____

Hemophilia Yes No DK

AIDS or HIV infection Yes No DK

Arthritis Yes No DK

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes No DK

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? Yes No DK

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: _____
