CORNERSTONE DENTAL

HEALTH HISTORY FORM

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. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: (Last Name) (First Name) (Middle In.) Cell Phone #:

Address: (Street) (City) (State) (Zip Code) Home Phone #:

Occupation: Height: Weight: Date of Birth: Sex: M F

SSN or Patient ID: Email:

Emergency Contact: Relationship: Contact #:

How did you hear about our practice?

How would you prefer to be contacted? ☐Text ☐Email ☐Phone

Dental Information

What is the reason for your dental visit today? _____

_____

How do you feel about your smile? What would you like to improve? _____

_____

Date of your last dental exam: _____ Date of Last Dental X-Rays: _____

What was done at that time? _____

Do your gums bleed when you brush or floss?.....YES NO

Are your teeth sensitive to cold, hot, sweets or pressure?.....YES NO

Is your mouth dry?.....YES NO

Have you had any periodontal (gum) treatments?.....YES NO

Have you ever had orthodontic (braces) treatment?.....YES NO

Have you ever had any problems associated with previous dental treatment?.....YES NO

Are you currently experiencing dental pain or discomfort?.....YES NO

Do you have any clicking, popping or discomfort in the jaw?.....YES NO

Do you brux or grind your teeth?.....YES NO

Do you have sores or ulcers in your mouth?.....YES NO

Do you wear dentures or partials?.....YES NO

Medical Information

Are you under the care of a physician?.....YES NO

Physician Name:_____ Phone: _____

Address/City/State/Zip: _____

Are you in good health?.....YES NO Date of Last Physical exam? _____

Have you had a serious illness, operations or been hospitalized in the past 5 years?.....YES NO

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 NO

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

_____

_____

Joint Replacement: Have you had an orthopedic total joint replacement?.....YES NO

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax*, Actonel*, Atelvia, Boniva*, Reclast, Prolia, Aredia*, Zometa*, XGEVA).....YES NO

Do you use controlled substances (drugs)?.....YES NO

Do you use tobacco?.....YES NO

Artificial (prosthetic) heart valve.....YES NO

Previous infective endocarditis.....YES NO

Congenital heart disease (CHD).....YES NO

Has a physician or dentist recommended that you take antibiotics prior to your dental treatment?.....YES NO

WOMEN ONLY Are you: Pregnant?..... YES NO Number of Weeks: _____

Taking birth control pills or hormonal replacement?.....YES NO

Allergies

Are you allergic to or have you had reactions to:

- ☐ Local anesthetics
- ☐ Aspirin
- ☐ Penicillin or other antibiotics
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Codeine or other narcotics
- ☐ Metals
- ☐ Latex (rubber)
- ☐ Other_____

Cardiovascular disease	YES	NO	Rheumatic heart disease	YES	NO
Cancer/Chemo/Radiation Treatment	YES	NO	Abnormal bleeding	YES	NO
Angina	YES	NO	Fainting spells or seizures	YES	NO
Gastrointestinal disease	YES	NO	Anemia	YES	NO
Congestive heart failure	YES	NO	Neurological disorders	YES	NO
Diabetes Type I or II	YES	NO	Blood transfusion	YES	NO
Eating disorder	YES	NO	Snoring	YES	NO
G.E. Reflux / Persistent Heartburn	YES	NO	AIDS or HIV infection	YES	NO
Heart Attack	YES	NO	Mental health disorders	YES	NO
Ulcers	YES	NO	Arthritis	YES	NO
Heart murmur	YES	NO	Autoimmune disease	YES	NO
Thyroid problems	YES	NO	Rheumatoid arthritis	YES	NO
High cholesterol	YES	NO	Kidney problems	YES	NO
High blood pressure	YES	NO	Asthma	YES	NO
Stroke	YES	NO	Emphysema	YES	NO
Glaucoma	YES	NO	Bronchitis	YES	NO
Congenital heart defect	YES	NO	Osteoporosis	YES	NO
Mitral Valve prolapse	YES	NO	Sinus trouble	YES	NO
Pacemaker	YES	NO	Tuberculosis	YES	NO
Hepatitis	YES	NO	Epilepsy	YES	NO

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: _____