



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

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

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:

- | | |
|---|---|
| <input type="checkbox"/> Local anesthetics | <input type="checkbox"/> Codeine or other narcotics |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Metals |
| <input type="checkbox"/> Penicillin or other antibiotics | <input type="checkbox"/> Latex (rubber) |
| <input type="checkbox"/> Barbiturates, sedatives, or sleeping pills | <input type="checkbox"/> 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: _____