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| **Health History** |

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| As required by our 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 law. This office doesn’t use this information to discriminate. |
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| Name (Last, First) |  |
| SSN |  | Date of Birth |  |
| Sex |  | Emergency Contact |  |
| Phone |  |
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| ***Medical History*** |  |
| Physician |  | Office Phone |  |
| Date of Last Exam |  |  |  |
| Are you under medical treatment now? |  Yes No |
| Have ever been hospitalized for any surgical operation or serious illness within the last 5 years? |  Yes No |
| If yes, please explain |  |
| Are you taking any medication(s) including non-prescription medicine? |  Yes No |
| If yes, what medication(s) are you taking? |  Yes No |
| Have you ever taken Fen-Phen/Redux? |  Yes No |
| Have you ever taken Fosamax, Boniva, Actoner or any cancer medications containing bisphosphonates? |  Yes No |
| Do you use tobacco? |  Yes No |
| Do you use controlled substances? |  Yes No |
| Do you have or have you had any of the following? |  Yes No |
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| High blood pressure |  | Yes |  | No | Heart Disease |  | Yes |  | No | Heart Attack |  | Yes |  | No |
| Cardiac Pacemaker |  | Yes |  | No | Rheumatic Fever |  | Yes |  | No | Heart Murmur |  | Yes |  | No |
| Swollen Ankles |  | Yes |  | No | Angina |  | Yes |  | No | Cancer |  | Yes |  | No |
| Frequently Tired |  | Yes |  | No | Asthma |  | Yes |  | No | Anemia |  | Yes |  | No |
| Low Blood Pressure |  | Yes |  | No | Emphysema |  | Yes |  | No | Diabetes |  | Yes |  | No |
| Fainting/Seizures |  | Yes |  | No | Leukemia |  | Yes |  | No | Arthritis |  | Yes |  | No |
| Epilepsy/Convulsions |  | Yes |  | No | Osteoporosis |  | Yes |  | No | Kidney Disease |  | Yes |  | No |
| Hepatitis/Jaundice |  | Yes |  | No | AIDS/HIV Infection |  | Yes |  | No | Thyroid Problem |  | Yes |  | No |
| Sexually Transmitted Disease |  | Yes |  | No | Stomach Troubles/Ulcers |  | Yes |  | No | Acid Reflex |  | Yes |  | No |
| Joint Replacement/Implant |  | Yes |  | No | Chest Pains |  | Yes |  | No | Easily Winded |  | Yes |  | No |
| Hay Fever/Allergies |  | Yes |  | No | Tuberculosis |  | Yes |  | No | Stroke |  | Yes |  | No |
| Radiation Therapy |  | Yes |  | No | Liver Disease |  | Yes |  | No | Glaucoma |  | Yes |  | No |
| Recent Weight Loss |  | Yes |  | No | Heart Trouble |  | Yes |  | No | Respiratory Problem |  | Yes |  | No |
| Mitral Valve Prolapse |  | Yes |  | No | Other |  |
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| ***Dental History*** |  |
| Name of Previous Dentist & Location |  |
| Date of Last Exam |  |
| 1. Do your gums bleed while brushing or flossing? |  Yes No |
| 2. Are your teeth sensitive to hot or cold or pressure or sweets? |  Yes No |
| 3. Does your mouth feel dry? |  Yes No |
| 4. Do you feel pain in any of your teeth? |  Yes No |
| 5. Do you have any sores or lumps in or near your mouth? |  Yes No |
| 6. In the past, |  |
| * Have you had any periodontal (gum) treatment?
 |  Yes No |
| * Have you had any problems with previous dental treatment?
 |  Yes No |
| * Have you had prolonged bleeding after extraction?
 |  Yes No |
| 7. Do you have any clicking/popping or discomfort in the jaws? |  Yes No |
| 8. Do you brux or grind your teeth? |  Yes No |
| 9. Do you have ulcers/sores in the mouth? |  Yes No |
| 10. Do you wear dentures/partials? |  Yes No |
| 11. Do you participate in active recreational activities? |  Yes No |
| 12. Have you ever had serious injury to head or mouth? |  Yes No |
| 13. Do you drink bottled/filtered water? |  Yes No |
| 14. Do you grind your teeth? |  Yes No |
| 15. Do you have any neck pains or earaches? |  Yes No |
| 16. Date of last Dental X-Rays |  Yes No |
| 17. What is the reason for your dental visit today? |  Yes No |
| 18. How do you feel about your smile? |  Yes No |
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| I certify that I have read and understood the above; and the information provided by me is accurate to the best of my knowledge. I understand that providing incorrect information can be deleterious to my health. I will not hold my dentist or his staff responsible for any action they take / do-not take because of errors or omissions that I have made in completion of this form.  |
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| Signature of Patient/Legal Guardian | Date |
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|  |  |
| Signature of Dentist | Date |
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| ***For completion by dentist*** |
| ***Comments*** |
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