

Health History Form

ADA American Dental Association

America's leading advocate for oral health

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	Yes	No	DK
Do you have any of the following diseases or problems: <i>(Check DK if you Don't Know the answer to the question)</i>				
Active Tuberculosis.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough greater than a 3 week duration.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough that produces blood.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been exposed to anyone with tuberculosis.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?			Date of your last dental exam:		
Do you drink bottled or filtered water?			What was done at that time?		
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY					
Are you currently experiencing dental pain or discomfort?.....			Date of last dental x-rays:		
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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you now under the care of a physician?			Have you had a serious illness, operation or been hospitalized in the past 5 years?		
Physician Name: _____ Phone: <i>Include area code</i> _____			If yes, what was the illness or problem? _____		
Address/City/State/Zip: _____			Are you taking or have you recently taken any prescription or over the counter medicine(s)?		
Are you in good health?			If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____		
Has there been any change in your general health within the past year?			_____		
If yes, what condition is being treated? _____			_____		
Date of last physical exam: _____			_____		

Medical Information 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) Yes No DK

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? _____

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? _____
(Circle one) VERY / SOMEWHAT / NOT INTERESTED

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

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? _____

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: _____

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

Allergies - Are you allergic to or have you had a reaction to: Yes No DK

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

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 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Autoimmune disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Hepatitis, jaundice or liver disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Previous infective endocarditis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Rheumatoid arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Damaged valves in transplanted heart <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Systemic lupus erythematosus <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Fainting spells or seizures <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Congenital heart disease (CHD)	Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Neurological disorders <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Unrepaired, cyanotic CHD <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	If yes, specify: _____
Repaired (completely) in last 6 months <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Sleep disorder <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Repaired CHD with residual defects <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Sinus trouble <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Mental health disorders <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Specify: _____
	Cancer/Chemotherapy/ Radiation Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Recurrent Infections <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
	Chest pain upon exertion <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Type of infection: _____
	Chronic pain <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Kidney problems <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
	Diabetes Type I or II <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Night sweats <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
	Eating disorder <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
	Malnutrition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Persistent swollen glands
	Gastrointestinal disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	in neck <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
	G.E. Reflux/persistent heartburn <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Severe headaches/ migraines <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
	Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Severe or rapid weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
	Thyroid problems <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Sexually transmitted disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Excessive urination <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	

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

Cardiovascular disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Mitral valve prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Angina <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Arteriosclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Rheumatic fever <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Congestive heart failure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Rheumatic heart disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Damaged heart valves <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Abnormal bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Heart murmur <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Blood transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Low blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	If yes, date: _____
High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Other congenital heart defects <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	AIDS or HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
	Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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: _____

SUBMIT

FOR COMPLETION BY DENTIST

Comments: _____

