Health History Form

Date: _____

Note: Follow-up questions may be asked to ensure we have all the right information for efficient treatment

Patient Information	
First Name	
Middle Name	
Last Name	
Home Phone	
Cell Phone	
Work Phone	
Email Address	
Mailing Address	
City	
State	
Zip	
Date of Birth	
Gender	
Occupation	
Emergency Contact	
Name	
Relationship	
Phone	
If you're completing this form for another individual, please state: **Name:** _____ **Relationship:** _____	

Dental History and Symptoms		
What is the reason for your visit today?		
Are you currently experiencing any dental pain or discomfort?		
☐ Yes ☐ No If **yes**, where? _____		
When was your last dental exam?		
Please list any procedures that occurred at that appointment.		
When was the last time you had dental x-rays?		
Please check the boxes **if** it applies to you.		
Hard to open mouth	☐ Yes ☐ No	
Hurts to chew, bite, or swallow	☐ Yes	☐ No
Bleeding gums when flossing or brushing	☐ Yes	☐ No

Have had periodontal (gum) treatments like scaling and root planing	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No
Clenching or grinding your teeth?	☐ Yes	☐ No
Jaw clicking, popping, or hurting	☐ Yes	☐ No
Earaches or neck pains	☐ Yes	☐ No
Nervousness when it comes to dental treatment	☐ Yes	☐ No
Experience of any of these sleep-related breathing disorders: mouth breathing, snoring, trouble breathing during sleep	☐ Yes	☐ No
Serious injury to head or mouth	☐ Yes	☐ No
If **yes**, please describe what happened and when it happened:		
Problems with dental treatment in the past	☐ Yes ☐ No	
If **yes**, please describe what happened:		
Reaction to, or problem with, dental anesthesia	☐ Yes ☐ No	
If **yes**, please describe what happened:		
Are you unhappy with your smile?	☐ Yes ☐ No	

If yes, why? Please tick the boxes that apply:

☐ The color of your teeth

☐ The shape of your teeth

☐ The position of your teeth

Other. Please describe _____

Medications and Other Products/Substances

Are you taking any blood thinners (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)?	☐ Yes	☐ No	☐ Unsure
If **yes**, what medication are you taking?:			
Are you taking any medication to treat osteoporosis or Paget's disease?	☐ Yes	☐ No	☐ Unsure
Some commonly-prescribed drugs include alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zolendronate (Reclast®), and denosumab (Prolia®)	☐ Yes	☐ No	☐ Unsure
If **yes**, what medication are you taking:			
Are you taking, or scheduled to take, an IV medication to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐ Yes	☐ No	☐ Unsure
Some commonly-prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®) or zolendronate (Zometa®).	☐ Yes	☐ No	☐ Unsure
If **yes**, what medication are you taking: How many years have you been taking it?:			

Are you taking hormonal replacements?	☐ Yes	☐ No	☐ Unsure
Do you use any form of tobacco or nicotine products (cigarettes, cigars, snuff, chew, bidis)?	☐ Yes	☐ No	☐ Unsure
Do you use vaping products?	☐ Yes	☐ No	☐ Unsure
How many alcoholic beverages do you have per week?			
Do you use controlled substances (drugs), including marijuana, for either medicinal or recreational reasons?	☐ Yes	☐ No	☐ Unsure

If **yes**, what substances?:

If **yes**, how often is your use?

☐ Daily

☐ Several times per week

☐ Weekly

☐ Occasionally

Was the substance prescribed by a doctor?

☐ Yes

☐ No

If **yes**, for what reason(s)? _____

Do you take any other prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements?	☐ Yes	☐ No	☐ Unsure

If **yes**, please list them here and include information about how much and how often you use each one:

WOMEN ONLY			
Are you taking birth control pills?	☐ Yes	☐ No	☐ Unsure
Are you pregnant? If **yes**, no. of weeks _____	☐ Yes	☐ No	☐ Unsure
Are you nursing? If **yes**, no. of weeks _____	☐ Yes	☐ No	☐ Unsure
Allergies			
If you're allergic to the following, please tick the '**yes**' box.			
Aspirin	☐ Yes	☐ No	☐ Unsure
Barbiturates, sedatives or sleeping pills	☐ Yes	☐ No	☐ Unsure
Codeine or other narcotics	☐ Yes	☐ No	☐ Unsure
Hay fever/seasonal allergies	☐ Yes	☐ No	☐ Unsure
Iodine	☐ Yes	☐ No	☐ Unsure
Latex (rubber)	☐ Yes	☐ No	☐ Unsure
Local anaesthetics	☐ Yes	☐ No	☐ Unsure
Metals	☐ Yes	☐ No	☐ Unsure
Penicillin or other antibiotics	☐ Yes	☐ No	☐ Unsure
Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim), erythromycin-sulfisoxazole, sulfasala-zine (Azulfidine), erythromycinsulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs), dapsone, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide (Microzide) and furosemide (Lasix)	☐ Yes	☐ No	☐ Unsure

Please note any other allergies:
If you have provided '**yes**' to any of these answers, please include information about your experience:

Medical and Surgical History

Date of last physical exam			
Doctor's Name			
Phone			
What is your normal blood pressure (e.g. systolic, diastolic)?			
Are you in good physical health?	☐ Yes	☐ No	☐ Unsure
Are you currently being seen or treated by a physician?	☐ Yes	☐ No	☐ Unsure
Has a physician or previous dentist recommended that you take antibiotics before having dental work done?	☐ Yes	☐ No	☐ Unsure
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐ Yes	☐ No	☐ Unsure
Have you had any type (either total or partial) of joint replacement surgery (such as for a hip, knee, shoulder, elbow, finger, etc.)?	☐ Yes	☐ No	☐ Unsure
Have you had a heart valve replacement or heart surgery?	☐ Yes	☐ No	☐ Unsure
Have you had an organ or bone marrow/stem cell transplant?	☐ Yes	☐ No	☐ Unsure
Have you traveled internationally within the last 30 days	☐ Yes	☐ No	☐ Unsure

Have you had a fever (100.4o F or above) in the last 72 hours?	☐ Yes	☐ No	☐ Unsure
If you answered **yes** to any of the above, please explain:			
Medical History Specific			
Do you have, or have you been diagnosed with, any of the following conditions?			
Heart (Cardiac) Health			
Pacemaker/implanted defibrillator	☐ Yes	☐ No	☐ Unsure
Artificial (prosthetic) heart valve	☐ Yes	☐ No	☐ Unsure
Previous infective endocarditis	☐ Yes	☐ No	☐ Unsure
Congenital heart disease (CHD)	☐ Yes	☐ No	☐ Unsure
Unrepaired, cyanotic CHD	☐ Yes	☐ No	☐ Unsure
Repaired (completely) in last 6 months	☐ Yes	☐ No	☐ Unsure
Repaired CHD with residual defects	☐ Yes	☐ No	☐ Unsure
Arteriosclerosis	☐ Yes	☐ No	☐ Unsure
Coronary artery disease	☐ Yes	☐ No	☐ Unsure
Congestive heart failure	☐ Yes	☐ No	☐ Unsure
Damaged heart valves	☐ Yes	☐ No	☐ Unsure

Heart attack	☐ Yes	☐ No	☐ Unsure
Heart murmur/rhythm disorder	☐ Yes	☐ No	☐ Unsure
Rheumatic heart disease	☐ Yes	☐ No	☐ Unsure
Stroke	☐ Yes	☐ No	☐ Unsure
Breathing (Respiratory) Health			
Asthma (COPD)	☐ Yes	☐ No	☐ Unsure
Bronchitis	☐ Yes	☐ No	☐ Unsure
Emphysema	☐ Yes	☐ No	☐ Unsure
Sinus trouble	☐ Yes	☐ No	☐ Unsure
Tuberculosis	☐ Yes	☐ No	☐ Unsure
Cancer			
Cancer presence Type: _____ Date of diagnosis: _____ Chemotherapy: _____ Radiation treatment: _____	☐ Yes	☐ No	☐ Unsure
Blood (Circulatory) Health			
Anemia	☐ Yes	☐ No	☐ Unsure
Blood transfusion If **yes**, date: _____	☐ Yes	☐ No	☐ Unsure

Hemophillia	☐ Yes	☐ No	☐ Unsure
High or low blood pressure	☐ Yes	☐ No	☐ Unsure
Brain (Neurological)/Mental Health			
Anxiety	☐ Yes	☐ No	☐ Unsure
Depression	☐ Yes	☐ No	☐ Unsure
Epilepsy	☐ Yes	☐ No	☐ Unsure
Mental health disorders	☐ Yes	☐ No	☐ Unsure
Neurological disorders	☐ Yes	☐ No	☐ Unsure
Post-traumatic stress disorder	☐ Yes	☐ No	☐ Unsure
Traumatic brain injury or concussion	☐ Yes	☐ No	☐ Unsure
Autoimmune Disease			
AIDS or HIV Infection	☐ Yes	☐ No	☐ Unsure
Lupus	☐ Yes	☐ No	☐ Unsure
Digestive Health			
Gastrointestinal disease	☐ Yes	☐ No	☐ Unsure
G.E. reflux/persistent heartburn (GERD)	☐ Yes	☐ No	☐ Unsure
Stomach ulcers	☐ Yes	☐ No	☐ Unsure
Eye (Vision) Health			

Glaucoma	☐ Yes	☐ No	☐ Unsure
Other			
Arthritis	☐ Yes	☐ No	☐ Unsure
Chronic pain	☐ Yes	☐ No	☐ Unsure
Diabetes (type I or II)	☐ Yes	☐ No	☐ Unsure
Eating disorder	☐ Yes	☐ No	☐ Unsure
Frequent infections Type of infection: _____	☐ Yes	☐ No	☐ Unsure
Hepatitis, jaundice or liver disease	☐ Yes	☐ No	☐ Unsure
Immune deficiency	☐ Yes	☐ No	☐ Unsure
Kidney problems	☐ Yes	☐ No	☐ Unsure
Malnutrition	☐ Yes	☐ No	☐ Unsure
Osteoporosis	☐ Yes	☐ No	☐ Unsure
Rheumatoid arthritis	☐ Yes	☐ No	☐ Unsure
Sexually transmitted infection (STI)	☐ Yes	☐ No	☐ Unsure
Thyroid problems	☐ Yes	☐ No	☐ Unsure
Do you have any disease, condition, or problem that's not listed here? If so, please explain:			

Medical Symptoms/General			
In the past 30 days, have you:			
Had pain or tightness in the chest?	☐ Yes	☐ No	☐ Unsure
Coughed up blood or had a cough that lasted longer than 3 weeks?	☐ Yes	☐ No	☐ Unsure
Been exposed to anyone with tuberculosis?	☐ Yes	☐ No	☐ Unsure
Had a rapid or irregular heart beat?	☐ Yes	☐ No	☐ Unsure
Found it hard to catch your breath?	☐ Yes	☐ No	☐ Unsure
Had a high fever (greater than 101.5˚F) for no reason?	☐ Yes	☐ No	☐ Unsure
Noticed a change in your vision?	☐ Yes	☐ No	☐ Unsure
Fainted for no reason?	☐ Yes	☐ No	☐ Unsure
Experienced vomiting, diarrhea, chills, night sweats or bleeding?	☐ Yes	☐ No	☐ Unsure
Had migraines or severe headaches?	☐ Yes	☐ No	☐ Unsure

Note: It's important for the doctor and patient to both talk honestly about the patient's health before treatment starts.

I have answered the above questions completely, and accurately and to the best of my ability.

Signature of Patient/Legal Guardian:

_____

Date:

_____

For Completion by Dentist				
Comments:				
Office Use Only:	Medical Alert ☐	Premedication ☐	Allergies ☐	Anesthesia ☐
Reviewed by: _____ **Date:** _____				