Health History Form

Name: _____ Date: _____

DENTAL INFORMATION

YES	NO	DON'T KNOW	
☐	☐	☐	Do you have headaches, or neck pains?
☐	☐	☐	Does your jaw pop, click, or hurt to open/close?
☐	☐	☐	Do you grind your teeth or clench?
☐	☐	☐	Have you even been told you have TMJ problems?
☐	☐	☐	Do you get cold sores or fever blisters?
☐	☐	☐	Are your teeth sensitive to cold, hot, or pressure?
☐	☐	☐	Do your gums bleed when you brush?
☐	☐	☐	Have you had any serious/difficult problem associated with any previous dental treatment? Explain: _____

YES	NO	DON'T KNOW	
☐	☐	☐	Do you snore loudly?
☐	☐	☐	Do you often feel fatigued or sleepy during daytime?
☐	☐	☐	Has anyone observed you stop breathing during your sleep?

How would you describe your current dental problem? _____

Date of your last dental exam _____ Name of last dentist _____

What was done at that time? _____ Date of last dental x-rays _____

How do you feel about the appearance of your teeth? _____ Do you have any problems with bad breath? _____

MEDICAL INFORMATION

YES	NO	DON'T KNOW	
☐	☐	☐	Are you in good health?
☐	☐	☐	Are you pregnant?
☐	☐	☐	Have there been any changes in your health within the past year? Explain: _____
☐	☐	☐	Are you under the care of a physician? If so, what conditions are being treated? _____

_____ Date of last exam _____

Physician: _____

Name Phone Address City/State/Zip

☐	☐	☐	Have you ever had any serious illness, operation, or been hospitalized in the past five years? If so, what was the illness or the problem? _____
☐	☐	☐	Do you drink soft drinks / sports drinks? If yes how many per day? _____
☐	☐	☐	Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the past week? _____ month? _____
☐	☐	☐	Are you alcohol and/or drug dependent? If so have you received treatment? (check one) ☐ YES ☐ NO
☐	☐	☐	Do you use drugs or other substances for recreational purposes? If yes, please list _____
☐	☐	☐	Do you use tobacco (smoking or chew)? If so, how interested are you in quitting? ☐ Very ☐ Somewhat ☐ Not at all
☐	☐	☐	How many years have or did you use tobacco? _____ How much tobacco did you use per day? _____

Are you taking any medications? If yes, for what purpose? PLEASE LIST BELOW

NAME OF DRUG	PURPOSE	DATE

Are you allergic or have you had a reaction to;

YES	NO	DON'T KNOW	
☐	☐	☐	Local Anesthetics
☐	☐	☐	Penicillin/Amoxicillin
☐	☐	☐	Barbiturates, sedatives, or sleeping pills
☐	☐	☐	Codeine or other narcotics
☐	☐	☐	Latex
☐	☐	☐	Metal
☐	☐	☐	Are you on Bisphosphonates?
☐	☐	☐	Other antibiotics (specify) _____
☐	☐	☐	Other allergy (specify) _____

Please (x) a response to indicate if you have or have had any of the following diseases or problems

YES	NO	DON'T KNOW	
☐	☐	☐	Abnormal Bleeding
☐	☐	☐	AIDS or HIV
☐	☐	☐	Anemia
☐	☐	☐	Arthritis
☐	☐	☐	Rheumatoid Arthritis
☐	☐	☐	Asthma
☐	☐	☐	Blood transfusion If yes, Date:_____
☐	☐	☐	Cancer/Chemotherapy/Radiation (circle)
☐	☐	☐	Cardiovascular diseases? If yes, please specify
			_____ Angina Pectoris
			_____ Heart murmur
			_____ Bypass Sugery
			_____ Mitral Valve Prolapse
			_____ Pacemaker
			_____ Rheumatic fever
			_____ Artificial valves
			_____ Heart attack – Date: _____
			_____ High Blood Pressure
☐	☐	☐	Chest Pain upon exertion
☐	☐	☐	Chronic Pain
☐	☐	☐	Disease, drug, or radiation-induced immunosuppression
☐	☐	☐	Diabetes. If yes, please specifiy
☐	☐	☐	_____ Type 1 (insulin dependent) _____ Type II
☐	☐	☐	Dry mouth
☐	☐	☐	Eating disorder. If yes, please specify _____
☐	☐	☐	Epilepsy
☐	☐	☐	Fainting spells/dizziness or seizures (circle one)
☐	☐	☐	Gastrointestinal Disease
☐	☐	☐	G.E. Reflux – persistent heartburn
☐	☐	☐	Glaucoma

YES	NO	DON'T KNOW	
☐	☐	☐	Hemophilia
☐	☐	☐	Hepatitis, Jaundice, or Liver Disease (circle one)
☐	☐	☐	Recurrent Infection
			If yes, indicate type of infection _____
☐	☐	☐	Mental Health disorder
☐	☐	☐	Night Sweats
☐	☐	☐	Neurological disorders
☐	☐	☐	Osteoporosis
☐	☐	☐	Persistant swollen glands
☐	☐	☐	Respiratory problems. If yes, please specify:
			___ Emphysema ___ Bronchitis, etc.
☐	☐	☐	Severe headaches/migraines
☐	☐	☐	Severe or rapid weight loss
☐	☐	☐	Sexually transmitted Disease
☐	☐	☐	Sinus Trouble
☐	☐	☐	Sores or ulcers in the mouth
☐	☐	☐	Stroke. If yes, Date:_____
☐	☐	☐	Systemic Lupus Erythematosus
☐	☐	☐	Tuberculosis
☐	☐	☐	Thyroid problems
☐	☐	☐	Ulcers
☐	☐	☐	Excessive urination
☐	☐	☐	Joint Replacement Location: _____
☐	☐	☐	Do you have any disease not listed above that you think we should know about? Please Explain: _____ _____
☐	☐	☐	Have you ever been told you needed to premedicate before your dental appointment?

I certify that I have read and understand the above. 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 because of errors or ommission that I may have made in the completion of this form.

_____ _____

SIGNATURE OF PATIENT/LEGAL GUARDIAN DATE

Date	Comments/Changes	Signature of patient	Signature of Dentist