

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?

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?

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: _____

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

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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____