Health History Form

Date_____

Patient Name_____ Height_____ Weight_____ Birth Date_____ Age____

Address_____City_____State_____Zip_____ Sex: __M ___F

Home( )_____Work( )_____Cell( )_____ SS#_____
Best time and place to reach you_____

__Married __Widowed __Single __Minor __Separated __Divorced ___Other

Occupation_____Patient's Employer_____Employer Phone( )_____

Spouse's Name_____ Spouse's Birth Date_____

Spouse's Work( )_____ Spouse's Cell ( )_____

In Case of Emergency, Contact Name_____

Relationship_____ Home( )_____ Work( )_____

Whom May We Thank For Referring You? _____

Children/Ages _____

Dental Information

Have you had any problems associated with previous dental treatment? Y/N

Are you currently experiencing dental pain or discomfort? Y/N

Name of last Dentist _____

Date of your last dental exam: _____ Date of last dental x-rays: _____
What is the reason for your dental visit today? _____

How do you feel about your smile?_____
Do you have or have your had any of the following?

- o Gums bleed when you Floss
- o Earaches/Neck Pain
- o Cold, hot, sweet or pressure sensitivity
- o Floss Catch between teeth
- o Dry Mouth
- o Had any periodontal/gum treatment

When?_____

- o Brux (grind) Teeth
- o Had orthodontic (braces) treatment

When? _____

- o Clicking, popping or jaw discomfort
- o Dentures or Partials
- o Ulcer or sores in your mouth
- o Head or mouth injury

When?_____

Medical Information

Physicians Name:_____ Phone: ( )_____

Address/City/State/Zip:_____

Are you in good health?____Yes ____No Date of last physical exam_____

Are you now under care of a physician? ____Yes ____No

If yes, what condition is being treated?_____

Do you have or have your had any of the following?

- o Actonel/ Risedronate when_____
- o AIDS/HIV Positive
- o Alzheimer's Disease
- o Alcoholic Beverages How often _____
- o Anaphylaxis
- o Anemia
- o Angina
- o Arteriosclerosis
- o Arthritis/Gout
- o Artificial Heart Valve
- o Artificial Joint
- o Asthma
- o Autoimmune Disease
- o Blood Disease
- o Blood Transfusion when_____
- o Bronchitis
- o Cancer _____
- o Chemotherapy
- o Chest Pains
- o Unrepaired Cyanotic (CHD)
- o Repaired (CHD) in the Last 6 months Any residual defects? _____
- o Chronic Pain
- o Cold Sores/Fever Blisters
- o Congenital Heart Disorder
- o Congestive Heart Failure
- o Contact Lenses
- o Convulsions
- o Diabetes type? I or II
- o Drug Addiction
- o Eating Disorder
- o Emphysema
- o Epilepsy or Seizures
- o Excessive Bleeding
- o Excessive Urination
- o Fainting Spells/Dizziness
- o Fosamax/Alendronate when_____
- o Frequent Headaches
- o Genital Herpes
- o Glaucoma
- o Heart Attack/Failure
- o Heart Murmur
- o Heart Pace Maker
- o Heart Trouble/Disease
- o Hemophilia
- o Hepatitis A
- o Hepatitis B or C
- o Herpes
- o High Blood Pressure
- o Hypoglycemia
- o Infective Endocarditis
- o Irregular Heartbeat
- o Kidney Problems
- o Leukemia
- o Low Blood Pressure
- o Lung Disease
- o Lupus
- o Malnutrition
- o Mitral Valve Prolapse
- o Night Sweats
- o Neurological Disorders _____
- o Organ Transplant
- o Osteoporosis
- o Pagets disease
- o Psychiatric Care
- o Radiation Treatments
- o Recent Weight Loss
- o Recurrent Infections_____
- o Rheumatic Fever
- o Rheumatism
- o Sinus Trouble
- o Sleep Disorders
- o Stomach/Intestinal Disease
- o Stroke
- o Swollen Glands in Neck
- o Tobacco _____
- o Thyroid Disease
- o Tuberculosis
- o Tumors or Growths
- o Ulcers
- o Venereal Disease
- o Yellow Jaundice

Allergy Information

Please check if you're allergic to any of the following:

- o Local anesthetics
- o Sulfa drugs
- o Codeine/other narcotics

- Hay Fever/Seasonal
- Penicillin/other antibiotics
- Aspirin
- Latex sensitivity
- Barbiturates, sedatives, sleeping pills
- Shellfish, Iodine or red wine
- Other_____

WOMEN ONLY

- Pregnant? Number of weeks?_____
- Birth Control Pills?

Do you have any disease, condition or problem not listed above that you think we should know about?_____

Please list all of the medications you are currently taking. Please include all OTC and Vitamins.

_____

_____

_____

Insurance Information

Will we be filing dental insurance for you Y/N

Subscribers Name_____

Subscribers SS# _____ Subscribers DOB _____

Do you have a secondary insurance that you would like us to file? Y/N

Subscribers Name _____

Subscribers SS# _____ Subscribers DOB_____

Note: Both Doctor and Patient are encouraged to discuss any and all relevant patient 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.

Patient/Guardian signed a copy after completing it in the patient's chart.