

Health History Form(Copy)

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Has there been any change to your general health within the past year?

☐ Yes ☐ No

If yes

Are you under a physician's care now? If so, for what condition?

☐ Yes ☐ No

If yes

Name, Address and Phone Number of your Physician

Have you ever been hospitalized or had a major operation within the last five years?

☐ Yes ☐ No

If yes

Do you require antibiotic prophylaxis prior to dental treatment? If Yes, for what condition?

☐ Yes ☐ No

If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?

☐ Yes ☐ No

If yes

Have you ever had a serious head or neck injury or radiation to this area?

☐ Yes ☐ No

If yes

Are you on a special diet?

☐ Yes ☐ No

If yes

Do you use tobacco? If yes, what type and with what frequency?

☐ Yes ☐ No

If yes

Are you on a Blood Thinner?

☐ Yes ☐ No

If yes

Are you taking a daily low dose aspirin?

☐ Yes ☐ No

If yes

Other medications?

☐ Yes ☐ No

If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant?

☐ Nursing?

☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin

☐ Penicillin

☐ Codeine

☐ Acrylic

☐ Metal

☐ Latex

☐ Sulfa Drugs

☐ Local Anesthetics

☐ Erythromycin

☐ Barbiturates

Other Allergies?

☐ Yes ☐ No

If yes

Do you use controlled substances?

☐ Yes ☐ No

If yes

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

AIDS/HIV Positive

☐ Yes ☐ No

Cortisone Medicine

☐ Yes ☐ No

Hemophilia

☐ Yes ☐ No

Radiation Treatments

☐ Yes ☐ No

Alzheimer's Disease

☐ Yes ☐ No

Diabetes

☐ Yes ☐ No

Hepatitis A

☐ Yes ☐ No

Recent Weight Loss

☐ Yes ☐ No

Anaphylaxis

☐ Yes ☐ No

Drug Addiction

☐ Yes ☐ No

Hepatitis B or C

☐ Yes ☐ No

Renal Dialysis

☐ Yes ☐ No

Anemia

☐ Yes ☐ No

Easily Winded

☐ Yes ☐ No

Herpes

☐ Yes ☐ No

Rheumatic Fever

☐ Yes ☐ No

Angina

☐ Yes ☐ No

Emphysema

☐ Yes ☐ No

High Blood Pressure

☐ Yes ☐ No

Rheumatism

☐ Yes ☐ No

Arthritis/Gout

☐ Yes ☐ No

Epilepsy or Seizures

☐ Yes ☐ No

High Cholesterol

☐ Yes ☐ No

Scarlet Fever

☐ Yes ☐ No

Artificial Heart Valve

☐ Yes ☐ No

Excessive Bleeding

☐ Yes ☐ No

Hives or Rash

☐ Yes ☐ No

Shingles

☐ Yes ☐ No

Artificial Joint

☐ Yes ☐ No

Excessive Thirst

☐ Yes ☐ No

Hypoglycemia

☐ Yes ☐ No

Sickle Cell Disease

☐ Yes ☐ No

Asthma

☐ Yes ☐ No

Fainting Spells/Dizziness

☐ Yes ☐ No

Irregular Heartbeat

☐ Yes ☐ No

Sinus Trouble

☐ Yes ☐ No

Blood Disease

☐ Yes ☐ No

Frequent Cough

☐ Yes ☐ No

Kidney Problems

☐ Yes ☐ No

Spina Bifida

☐ Yes ☐ No

Blood Transfusion

☐ Yes ☐ No

Frequent Diarrhea

☐ Yes ☐ No

Leukemia

☐ Yes ☐ No

Stomach/Intestinal Disease

☐ Yes ☐ No

Breathing Problems

☐ Yes ☐ No

Frequent Headaches

☐ Yes ☐ No

Liver Disease

☐ Yes ☐ No

Stroke

☐ Yes ☐ No

Bruise Easily

☐ Yes ☐ No

Genital Herpes

☐ Yes ☐ No

Low Blood Pressure

☐ Yes ☐ No

Swelling of Limbs

☐ Yes ☐ No

Cancer

☐ Yes ☐ No

Glaucoma

☐ Yes ☐ No

Lung Disease

☐ Yes ☐ No

Thyroid Disease

☐ Yes ☐ No

Chemotherapy

☐ Yes ☐ No

Hay Fever

☐ Yes ☐ No

Mitral Valve Prolapse

☐ Yes ☐ No

Tonsillitis

☐ Yes ☐ No

Chest Pains

☐ Yes ☐ No

Heart Attack/Failure

☐ Yes ☐ No

Osteoporosis

☐ Yes ☐ No

Tuberculosis

☐ Yes ☐ No

Cold Sores/Fever Blisters

☐ Yes ☐ No

Heart Murmur

☐ Yes ☐ No

Pain in Jaw Joints

☐ Yes ☐ No

Tumors or Growths

☐ Yes ☐ No

Congenital Heart Disorder

☐ Yes ☐ No

Heart Pacemaker

☐ Yes ☐ No

Parathyroid Disease

☐ Yes ☐ No

Ulcers

☐ Yes ☐ No

Convulsions

☐ Yes ☐ No

Heart Trouble/Disease

☐ Yes ☐ No

Psychiatric Care

☐ Yes ☐ No

Venereal Disease

☐ Yes ☐ No

Jaundice

☐ Yes ☐ No

Healing Complications

☐ Yes ☐ No

Anorexia

☐ Yes ☐ No

Bulimia

☐ Yes ☐ No

Have you ever had any serious illness not listed

☐ Yes ☐ No

If yes

Are your teeth sensitive to...

Hot or Cold

☐ Yes ☐ No

Biting/chewing

☐ Yes ☐ No

Sweets

☐ Yes ☐ No

Have you ever had...

Orthodontic Treatment ☐ Yes ☐ No

Periodontal Treatment ☐ Yes ☐ No

Occlusal Night Guard ☐ Yes ☐ No

Oral Surgery ☐ Yes ☐ No

Do you have a current dental health concern that you would like addressed?

☐ Yes ☐ No

If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. Parents of minors: If a responsible adult is not present at the time of treatment, we will provide standard and correct therapy, including the use of necessary x-rays.

Signature of Patient, Parent or Guardian:

X

Date: _____