Office Use
Pre-medication_____

Health History Form

Date_____ Medical Alert_____
Allergies_____

Name_____ Date of Birth_____ Age _____
If you are completing this form for another person, what is your relationship to that person? _____

Your Answers are kept confidential. This information is vital to allow us to provide appropriate care for you.

Dental Information

Previous Dentist_____
Last Dental Visit_____ Last Complete Dental Exam/Cleaning_____ Last Dental X-Ray_____
What is your Immediate Concern?_____

Yes	No		Yes	No	
□	□	Do your gums bleed?	□	□	Do you have head aches, earaches, neck pain?
□	□	Are your teeth sensitive to cold, hot, sweets or pressure?	□	□	Have you ever had orthodontic treatment?
□	□	Have you had any periodontal (gum) treatment?	□	□	Do you wear a removable appliance?
□	□	Do you clench/grind your teeth during the day or night?	□	□	Do you get cold sores or canker sores?

□ □ Are you aware of your jaw clicking or popping while eating or yawning? How often? _____
□ □ Have you had a serious/difficult problem associated with any previous dental treatment?
If so, explain _____
How do you feel about the appearance of your teeth? _____

Medical Information

Primary Physician _____ Phone # _____

Yes No
□ □ Are you in good health?
□ □ Have there been any changes in your health within the last year?(explain) _____
_____
□ □ Are you under the care of a physician? If so, what is/are the condition(s) being treated?_____
_____Date of last exam _____
Physicians(s) Name _____ Phone # _____
_____ Phone # _____
□ □ Have you had any serious illness, operation, or been hospitalized in the last 5 years? If so, what was the illness or problem? _____

Medications

Yes No
□ □ Are you taking or recently taken medicine(s) including non-prescription medicine(s)? If so, what medicine(s)? (please list medication name, dosage, and how often the medication is taken)
1._____ 2._____
3._____ 4._____
5._____ 6._____
7._____ 8._____
□ □ Do you drink alcoholic beverages? If yes, how often? _____
□ □ Do you use drugs or other substances for recreational purposes? If so, how often?_____
□ □ Do you use tobacco (smoking, chewing, snuff)? If so, are you interested in stopping? □ interested □ not interested
Frequency of use? _____ pack(s) per day for _____ # of years.

Allergies

Are you allergic to or have you had a reaction to: (Please fill out completely)

Yes	No		Yes	No	
□	□	Local anesthetics	□	□	Latex
□	□	Aspirin	□	□	Iodine
□	□	Penicillin or other antibiotics	□	□	Metals (jewelry)
□	□	Barbituates, sedatives, or sleeping pills	□	□	Hayfever/Seasonal
□	□	Sulfa drugs	□	□	Food (specify)_____
□	□	Codeine or Narcotics	□	□	Other _____

If yes to any of the above please specify type of reaction_____
_____

(Please fill out back form)

Health History Form (Continued)

Yes No

□ □ Do you have or have you ever been diagnosed with a heart murmur?

□ □ Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?
What operation(s)?_____Date(s)_____

□ □ Have you had any complications or difficulties with your prosthetic joint?

□ □ Are you immune compromised?

□ □ Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?
What antibiotic?_____ What dose? _____

General Health Information

Please (X) if you have or had any of the following diseases or problems

Yes No

□ □ Abnormal bleeding
□ □ AIDS or HIV infection
□ □ Anemia
□ □ Arthritis
□ □ Rheumatoid arthritis
□ □ Asthma
□ □ Blood
If yes, when _____
□ □ Cancer/chemotherapy/radiation
□ □ Cardiovascular disease
If yes, specify below:
O Angina
O Arteriosclerosis
O Artificial heart valve
O Coronary Insufficiency
O Coronary occlusion
O Damaged heart valves
O Heart attack
O Heart murmur
O High blood
O Inborn heart defect
O Mitral valve prolapse
O Pace Maker
O Rheumatic heart disease
□ □ Chest pain upon exertion
□ □ Chronic pain

Yes No

□ □ Disease, drug, or radiation-induced immunosupression
□ □ Diabetes. If yes, specify below:
O Type I (insulin dependent)
O Type II
□ □ Dry mouth
□ □ Eating disorder
If yes, when? _____
□ □ Epilepsy
□ □ Fainting spell or seizures
□ □ G. I. reflux
□ □ Glaucoma
□ □ Hemophilia
□ □ Hepatitis, jaundice, or liver disease
□ □ Kidney problems
□ □ Low blood pressure
□ □ Mental health disorders
If yes explain:_____
_____
□ □ Malnutrition
□ □ Migraines
□ □ Night sweats
□ □ Neurological disorders. If yes, specify_____

Yes No

□ □ Respiratory problems
If yes specify below:
O Emphysema
O Bronchitis, etc
□ □ Sever headaches
□ □ Severe rapid weight loss
□ □ Sexually transmitted disease
□ □ Sinus trouble
□ □ Sores or ulcers in the mouth
□ □ Stroke
□ □ Systemic lupus erythematosus
□ □ Thyroid problems
□ □ Tuberculosis
□ □ Ulcers
□ □ Excessive urination
□ □ Do you have ay disease, condition or problem not listed? If yes explain. _____
_____
_____
_____
_____
_____

Women Only

Yes No

□ □ Are you or is it possible you may be pregnant?
□ □ Are you nursing?
□ □ Taking birth control pills?

Note: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in completion of this form.

Signature of Patient/Legal Guardian _____Date _____

Medical Management Notes

BP:_____ Pulse:_____

Health History Update:

On a regular basis patients should be questioned about any medical history changes, date and comments noted.

Date	Comments	Initials
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	