

# Health History Form

**ADA** American Dental Association®

America's leading advocate for oral health

E-mail:

Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

|                        |                    |               |                                      |   |
|------------------------|--------------------|---------------|--------------------------------------|---|
| Name:                  |                    |               | Home Phone: <i>Include area code</i> | Business/Cell Phone: <i>Include area code</i> |
| Last                   | First              | Middle        | ( )                                  | ( )   |
| Address:               |                    |               | City:                                | State: Zip:                                   |
| <i>Mailing address</i> |                    |               |                                      |   |
| Occupation:            | Height:            | Weight:       | Date of birth:                       | Sex: M F                                      |
| SS# or Patient ID:     | Emergency Contact: | Relationship: | Home Phone: ( )                      | Cell Phone: ( )                               |
|                        |                    |               | <i>Include area codes</i>            |   |

If you are completing this form for another person, what is your relationship to that person?

Your Name Relationship

**Do you have any of the following diseases or problems:** (Check DK if you Don't Know the answer to the question) Yes No DK

- Active Tuberculosis.....
- Persistent cough greater than a 3 week duration.....
- Cough that produces blood.....
- Been exposed to anyone with tuberculosis.....

**If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.**

## Dental Information *For the following questions, please mark (X) your responses to the following questions.*

|   | Yes                      | No                       | DK                       |   | Yes                      | No                       | DK                       |
|---|--------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|--------------------------|
| Do your gums bleed when you brush or floss? .....                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you have earaches or neck pains? .....                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are your teeth sensitive to cold, hot, sweets or pressure? .....          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any clicking, popping or discomfort in the jaw? ..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Does food or floss catch between your teeth? .....                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you brux or grind your teeth? .....                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Is your mouth dry?.....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you have sores or ulcers in your mouth? .....                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any periodontal (gum) treatments? .....                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear dentures or partials? .....                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had orthodontic (braces) treatment? .....                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you participate in active recreational activities? .....       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any problems associated with previous dental treatment?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a serious injury to your head or mouth?.....    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Is your home water supply fluoridated? .....                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Date of your last dental exam:                                    |                          |                          |                          |
| Do you drink bottled or filtered water? .....                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | What was done at that time?                                       |                          |                          |                          |
| If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY              |                          |                          |                          | Date of last dental x-rays:                                       |                          |                          |                          |
| Are you currently experiencing dental pain or discomfort? .....           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |                          |
| What is the reason for your dental visit today?                           |                          |                          |                          |   |                          |                          |                          |
| How do you feel about your smile?   |                          |                          |                          |   |                          |                          |                          |

## Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

|  | Yes                      | No                       | DK                       |   | Yes                      | No                       | DK                       |
|--|--------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|--------------------------|
| Are you now under the care of a physician? .....                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you had a serious illness, operation or been hospitalized in the past 5 years? .....           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Physician Name:  |                          |                          |                          | If yes, what was the illness or problem?  |                          |                          |                          |
| Phone: <i>Include area code</i>  |                          |                          |                          |   |                          |                          |                          |
| ( )  |                          |                          |                          |   |                          |                          |                          |
| Address/City/State/Zip:  |                          |                          |                          | Are you taking or have you recently taken any prescription or over the counter medicine(s)? .....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          |                          | If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: |                          |                          |                          |
| Are you in good health? .....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |                          |                          |                          |
| Has there been any change in your general health within the past year? ..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |                          |                          |                          |
| If yes, what condition is being treated?                                     |                          |                          |                          | _____   |                          |                          |                          |
|  |                          |                          |                          | _____   |                          |                          |                          |
| Date of last physical exam:  |                          |                          |                          |   |                          |                          |                          |

**Medical Information** Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)

Do you wear contact lenses?  Yes  No  DK

**Joint Replacement.** Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?  Yes  No  DK

Date: \_\_\_\_\_ If yes, have you had any complications? \_\_\_\_\_

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?  Yes  No  DK

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?  Yes  No  DK

Date Treatment began: \_\_\_\_\_

**Allergies** - Are you allergic to or have you had a reaction to: To all **yes** responses, specify type of reaction.  Yes  No  DK

Local anesthetics  Yes  No  DK

Aspirin  Yes  No  DK

Penicillin or other antibiotics  Yes  No  DK

Barbiturates, sedatives, or sleeping pills  Yes  No  DK

Sulfa drugs  Yes  No  DK

Codeine or other narcotics  Yes  No  DK

Do you use controlled substances (drugs)?  Yes  No  DK

Do you use tobacco (smoking, snuff, chew, bidis)?  Yes  No  DK

If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages?  Yes  No  DK

If yes, how much alcohol did you drink in the last 24 hours? \_\_\_\_\_

If yes, how much do you typically drink in a week? \_\_\_\_\_

**WOMEN ONLY** Are you:

Pregnant?  Yes  No  DK

Number of weeks: \_\_\_\_\_

Taking birth control pills or hormonal replacement?  Yes  No  DK

Nursing?  Yes  No  DK

Metals  Yes  No  DK

Latex (rubber)  Yes  No  DK

Iodine  Yes  No  DK

Hay fever/seasonal  Yes  No  DK

Animals  Yes  No  DK

Food  Yes  No  DK

Other  Yes  No  DK

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Artificial (prosthetic) heart valve  Yes  No  DK

Previous infective endocarditis  Yes  No  DK

Damaged valves in transplanted heart  Yes  No  DK

Congenital heart disease (CHD)

Unrepaired, cyanotic CHD  Yes  No  DK

Repaired (completely) in last 6 months  Yes  No  DK

Repaired CHD with residual defects  Yes  No  DK

Autoimmune disease  Yes  No  DK

Rheumatoid arthritis  Yes  No  DK

Systemic lupus erythematosus  Yes  No  DK

Asthma  Yes  No  DK

Bronchitis  Yes  No  DK

Emphysema  Yes  No  DK

Sinus trouble  Yes  No  DK

Tuberculosis  Yes  No  DK

Cancer/Chemotherapy/ Radiation Treatment  Yes  No  DK

Chest pain upon exertion  Yes  No  DK

Chronic pain  Yes  No  DK

Diabetes Type I or II  Yes  No  DK

Eating disorder  Yes  No  DK

Malnutrition  Yes  No  DK

Gastrointestinal disease  Yes  No  DK

G.E. Reflux/persistent heartburn  Yes  No  DK

Ulcers  Yes  No  DK

Thyroid problems  Yes  No  DK

Stroke  Yes  No  DK

Glaucoma  Yes  No  DK

Hepatitis, jaundice or liver disease  Yes  No  DK

Epilepsy  Yes  No  DK

Fainting spells or seizures  Yes  No  DK

Neurological disorders  Yes  No  DK

If yes, specify: \_\_\_\_\_

Sleep disorder  Yes  No  DK

Mental health disorders  Yes  No  DK

Specify: \_\_\_\_\_

Recurrent Infections  Yes  No  DK

Type of infection: \_\_\_\_\_

Kidney problems  Yes  No  DK

Night sweats  Yes  No  DK

Osteoporosis  Yes  No  DK

Persistent swollen glands in neck  Yes  No  DK

Severe headaches/ migraines  Yes  No  DK

Severe or rapid weight loss  Yes  No  DK

Sexually transmitted disease  Yes  No  DK

Excessive urination  Yes  No  DK

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Cardiovascular disease  Yes  No  DK

Angina  Yes  No  DK

Arteriosclerosis  Yes  No  DK

Congestive heart failure  Yes  No  DK

Damaged heart valves  Yes  No  DK

Heart attack  Yes  No  DK

Heart murmur  Yes  No  DK

Low blood pressure  Yes  No  DK

High blood pressure  Yes  No  DK

Other congenital heart defects  Yes  No  DK

Mitral valve prolapse  Yes  No  DK

Pacemaker  Yes  No  DK

Rheumatic fever  Yes  No  DK

Rheumatic heart disease  Yes  No  DK

Abnormal bleeding  Yes  No  DK

Anemia  Yes  No  DK

Blood transfusion  Yes  No  DK

If yes, date: \_\_\_\_\_

Hemophilia  Yes  No  DK

AIDS or HIV infection  Yes  No  DK

Arthritis  Yes  No  DK

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?  Yes  No  DK

Name of physician or dentist making recommendation: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have any disease, condition, or problem not listed above that you think I should know about?  Yes  No  DK

Please explain: \_\_\_\_\_

**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 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.

Signature of Patient/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR COMPLETION BY DENTIST**

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_