HEALTH HISTORY FORM

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: (LAST FIRST MIDDLE) Home Phone: ( ) Work Phone: ( ) Cell Phone: ( )

Address: (MAILING ADDRESS) City: State: Zip:

Occupation: Height: Weight: Date of birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: ( ) Cell Phone: ( ) (INCLUDE AREA CODES)

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

(YOUR NAME) (RELATIONSHIP)

Would you like to sign for our monthly Health News Letter (Sent via email only once a month)? Yes ☐ No ☐

List all the countries you have visited in the past 12 months?

DENTAL INFORMATION

For the following questions, please mark (X) your responses to the following questions. (DK - Don't Know)

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment? If yes, please describe below.	☐	☐	☐
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have ear aches or neck pain?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?			

Date of your last dental visit: _____

Reason for last dental visit:

Date of last dental x-rays:

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. (DK - Don't Know)

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

Physician Name: Phone: (Include area code) ( )

Address/City/State/Zip:

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If yes, what was the illness or problem?

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

_____

_____

_____

MEDICAL INFORMATION

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems. (DK - Don't Know)

(CHECK DK IF YOU DON'T KNOW THE ANSWER TO THE QUESTION)

Sleep Apnae Questionnaire

	Yes	No	DK
Do you think you snore?	☐	☐	☐
Do you often feel tired, fatigued or sleepy during day time?	☐	☐	☐
Has anyone observed you stop breathing during your sleep?	☐	☐	☐
Do you have or are you being treated for high blood pressure?	☐	☐	☐
BMI more than 35?	☐	☐	☐
Age over 50 years old?	☐	☐	☐
Neck circumference more than16 inches?	☐	☐	☐
Gender: Male?	☐	☐	☐

(*Please refer to Obstructive Sleep Apnae (OSA) Brochure for details)

High risk of OSA: Yes 5-8

Intermediate risk of OSA: Yes 3-4

Low risk of OSA: Yes 0-2

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)? (Circle one)	☐	☐	☐
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much do you typically drink In a week?			

WOMEN ONLY Are you:

Pregnant?	☐	☐	☐
Number of weeks:			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

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	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Metals	☐	☐	☐
Latex (rubber)	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food	☐	☐	☐
Other	☐	☐	☐

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

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure			
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date:			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify:			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify:			
Recurrent Infections	☐	☐	☐
Type of infection:			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation: | Phone:

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

Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all patient health issues prior to treatment.

I certify that I have read and understood 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.

Name of Patient/Legal Guardian	Signature of Patient/Legal Guardian:	Date:

Review by: DENTIST NAME:	DENTIST SIGNATURE:	Date:

Comments:

For Office Use Only: ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia Reviewed by

Date