Health History Form

Patient Name:_____ **Today's Date:**_____

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

Relationship: _____ Your Name: _____

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

	Yes	No	DK (*don't know*)
Do your gums bleed when you brush or floss?	__	__	__
Are your teeth sensitive to cold, hot, sweets or pressure?	__	__	__
Does food or floss catch between your teeth?	__	__	__
Is your mouth dry?	__	__	__
Have you had any periodontal (gum) treatments?	__	__	__
Have you had orthodontic (braces) treatment?	__	__	__
Have you had any problems associated with previous dental treatment?	__	__	__
Is your home water supply fluoridated?	__	__	__
Are you currently in dental pain or discomfort?	__	__	__

	Yes	No	DK
Do you have any clicking, popping, or discomfort in the jaw?	__	__	__
Do you grind or clench your teeth?	__	__	__
Do you get sores or ulcers in your mouth?	__	__	__
Do you wear dentures or partial dentures?	__	__	__
Have you had a serious injury to your head or mouth?	__	__	__

When was your last dental visit? _____

What services were provided at that visit? _____

Date of last x-rays:_____

What is the reason for your visit today? _____

Medical Information

	Yes	No	DK
Are you now under the care of a physician?	__	__	__
Are you in good health?	__	__	__
Are you currently taking any prescription or over the counter medicines?	__	__	__

Physician Name:_____

Physician Phone: ( ) _____- _____

Physician Address/City/State/Zip:

_____

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 currently being treated for any conditions?	__	__	__

If yes, what was the illness or problem?

_____

_____

If yes, what conditions are being treated?_____

_____

Please list all medicines, vitamins, natural or herbal preparations and/or supplements ON THE BACK of this form.

	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 diease, multiple myeloma or metastatic cancer?	__	__	__

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

If so, how interested are you in stopping?

(Circle One) VERY / SOMEWHAT / NOT INTERESTED

	Yes	No	DK
Do you use recreational drugs?	__	__	__
Do you drink alcoholic beverages?	__	__	__

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

_____

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

Date: _____ Surgeon:_____ Have you had any complications?_____

Women Only:

	Yes	No	DK
Are you pregnant?	__	__	__
Taking birth control pills or hormonal replacement?	__	__	__
Are you nursing?	__	__	__

Number of Weeks: _____

Allergies: Are you allergic to or had a reaction to: (To all YES responses, specify type of reaction.)

Local anesthetics_____

Penicillin or other antibiotics_____

Codeine or other narcotics_____

Latex_____

Metals_____

Sulfa Drugs_____

Barbiturates, sedatives, or sleeping pills_____

Food/Milk_____

Other Allergies:_____

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

Name of physician or dentist making recommendation: _____

Phone: ( ) _____ - _____

Medical Information

Please list all medications, including vitamins, natural or herbal preparations and/or diet supplements below:

Date	Medication	Condition

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

	Yes	No	DK
Cardiovascular disease	___	___	___
Angina	___	___	___
Arteriosclerosis	___	___	___
Congestive heart failure	___	___	___
Congenital heart disease	___	___	___
Coronary artery disease	___	___	___
Damaged or replaced heart valves	___	___	___
Heart attack	___	___	___
Low blood pressure	___	___	___
High blood pressure	___	___	___
Abnormal bleeding	___	___	___
Anemia	___	___	___
Blood transfusion	___	___	___
If Yes, Date: _____			
Hemophilia	___	___	___
AIDS or HIV infection	___	___	___
Arthritis	___	___	___
Autoimmune disease	___	___	___
Rheumatoid disease	___	___	___
Systemic lupus (erythematosus)	___	___	___
Asthma	___	___	___
Emphysema	___	___	___
Sinus trouble	___	___	___
Cancer/Chemotherapy/Radiation Treatment	___	___	___
Chest pain upon exertion	___	___	___

	Yes	No	DK
Chronic Pain	___	___	___
Diabetes Type I or II	___	___	___
Eating Disorder	___	___	___
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 infections:_____			
Kidney problems	___	___	___
Night sweats	___	___	___
Osteoporosis	___	___	___
Persistent swollen glands in neck	___	___	___
Severe headaches/migraines	___	___	___
Severe or rapid weight loss	___	___	___
Sexually transmitted disease	___	___	___
Excessive urination	___	___	___

Do you have any disease, condition, or problem not listed above that you think we should be aware of?
If so, 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: _____

_____

_____

_____

_____

_____
Dentist Signature/Date

Blood Pressure	**Date**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Health History Updates

Any Changes?	Yes/No	Date:_____	Patient Initials:_____
Any Changes?	Yes/No	Date:_____	Patient Initials:_____
Any Changes?	Yes/No	Date:_____	Patient Initials:_____
Any Changes?	Yes/No	Date:_____	Patient Initials:_____
Any Changes?	Yes/No	Date:_____	Patient Initials:_____
Any Changes?	Yes/No	Date:_____	Patient Initials:_____

For Office Use Only: Changes to Patient Health History

Date	Changes	Intials