

Health History Form



American Dental Association
www.ada.org

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: <i>Include area code</i> ()	Business/Cell Phone: <i>Include area code</i> ()
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: () <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: <i>(Check DK if you Don't Know the answer to the question)</i>	
Active Tuberculosis	Yes No DK
Persistent cough greater than a 3 week duration	Yes No DK
Cough that produces blood.....	Yes No DK
Been exposed to anyone with tuberculosis	Yes No DK

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.*

Do your gums bleed when you brush or floss?	Yes No DK	Do you have earaches or neck pains?	Yes No DK
Are your teeth sensitive to cold, hot, sweets or pressure?	Yes No DK	Do you have any clicking, popping or discomfort in the jaw?	Yes No DK
Does food or floss catch between your teeth?	Yes No DK	Do you brux or grind your teeth?	Yes No DK
Is your mouth dry?	Yes No DK	Do you have sores or ulcers in your mouth?	Yes No DK
Have you had any periodontal (gum) treatments?	Yes No DK	Do you wear dentures or partials?	Yes No DK
Have you ever had orthodontic (braces) treatment?	Yes No DK	Do you participate in active recreational activities?	Yes No DK
Have you had any problems associated with previous dental treatment?	Yes No DK	Have you ever had a serious injury to your head or mouth?	Yes No DK
Is your home water supply fluoridated?	Yes No DK	Date of your last dental exam:	
Do you drink bottled or filtered water?	Yes No DK	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?	Yes No DK		
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.*

Are you now under the care of a physician?	Yes No DK	Have you had a serious illness, operation or been hospitalized in the past 5 years?	Yes No DK
Physician Name:	Phone: <i>Include area code</i> ()	If yes, what was the illness or problem?	
Address/City/State/Zip:		Are you taking or have you recently taken any prescription or over the counter medicine(s)?	Yes No DK
Are you in good health?	Yes No DK	If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:	
Has there been any change in your general health within the past year?	Yes No DK	_____	
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)	Yes	No	DK		Yes	No	DK
Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use controlled substances (drugs)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use tobacco (smoking, snuff, chew, bidis)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcoholic beverages?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date Treatment began: _____				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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Number of weeks: _____			
				Taking birth control pills or hormonal replacement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Nursing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

Date: _____ If yes, have you had any complications?

Allergies - Are you allergic to or have you had a reaction to:	Yes	No	DK		Yes	No	DK
To all yes responses, specify type of reaction.				Metals _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Local anesthetics _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex (rubber) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/seasonal _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Animals _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	Yes	No	DK	Yes	No	DK				
Heart murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I or II.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date: _____				Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____			
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infections.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV infection.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type of infection: _____			
Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G.E. Reflux/persistent heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronary artery disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus erythematosus.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent swollen glands in neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe headaches/migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice or liver disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe or rapid weight loss..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells or seizures ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Chemotherapy/ Radiation Treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, Specify: _____							
Rheumatic heart disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain upon exertion ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												

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 I should know about?

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: _____
