Health History Form

Name_____ Date of Birth:_____ Sex: M F

Address:_____ City:_____ State:_____ Zip:_____

Home Phone: _____ Business/Cell Phone:_____ Occupation:_____

Email:_____ How did you find out about us:_____

Emergency Contact:_____ Emerg. Contact Phone: _____

Medical History

Please indicate if you have or have not had any of the following:

	Yes	No		Yes	No
Artificial heart valve	☐	☐	Autoimmune Disease	☐	☐
Previous infective endocarditis	☐	☐	Arthritis/Rheumatoid	☐	☐
Cardiovascular disease	☐	☐	Asthma	☐	☐
Mitral Valve Prolapse	☐	☐	Emphysema/COPD	☐	☐
Pacemaker	☐	☐	Tuberculosis	☐	☐
Rheumatic Fever	☐	☐	Diabetes Type I or II	☐	☐
Angina	☐	☐	Cancer/Chemotherapy	☐	☐
Heart Attack	☐	☐	Radiation	☐	☐
Stroke	☐	☐	G.E.R.D.	☐	☐
Heart murmur	☐	☐	Hepatitis A,B,C/Jaundice	☐	☐
High Blood Pressure	☐	☐	Epilepsy	☐	☐
Abnormal Bleeding	☐	☐	Fainting Spells/Seizures	☐	☐
Blood Transfusions	☐	☐	Mental Health Disorders	☐	☐
HIV/AIDS	☐	☐	Severe headaches/Migraines	☐	☐

	Yes	No
Are you now under the care of a physician:	☐	☐

Physician's Name:
_____
Phone:_____
Date of last exam_____

	Yes	No
Are you taking any prescription or over the counter medications?	☐	☐

Please list medications (including herbal and dietary supplements):_____
_____
_____
_____
_____
_____
_____

	Yes	No
Are you in good health?	☐	☐
Has there been any change in your health over the last year?	☐	☐

If yes, please explain
_____
_____
_____

	Yes	No
Have you ever had an orthopedic total joint replacement (knee, hip, elbow, etc.)?	☐	☐

If yes, Date of Replacement:_____
Did you have any complications?
_____
_____
_____

Allergies: Are you allergic to or have you ever had a reaction to:	Yes	No
Local Anesthetics	☐	☐
Penicillin	☐	☐
Other antibiotics	☐	☐
Sulfa drugs	☐	☐
Codeine	☐	☐
Latex	☐	☐
Metals	☐	☐

Please list any other known allergies:

_____

_____

_____

_____

_____

	Yes	No
Have you ever needed to take an antibiotic prior to dental treatment?	☐	☐
Have you ever taken any medications for osteoporosis?	☐	☐
Have you ever had a history of drug abuse?	☐	☐

Women:	Yes	No
Are you pregnant?	☐	☐
# of weeks_____		
Are you nursing?	☐	☐
Are you taking birth control?	☐	☐
If so, which one:		
_____		

Dental History

	Yes	No
Do your gums bleed when you brush?	☐	☐
Are your teeth sensitive? (hot, cold, sweet)	☐	☐
Is your mouth dry?	☐	☐
Have you ever been diagnosed with periodontal disease?	☐	☐
Have you ever had any problems with a dental procedure in the past?	☐	☐
Are you currently experiencing any dental pain or discomfort?	☐	☐
Explain_____		
Do you use any type of tobacco products?	☐	☐

	Yes	No
Do you ever have neck pain or earaches?	☐	☐
Do you have any discomfort in your jaws?	☐	☐
Are you a grinder or clencher?	☐	☐
Date of your last dental visit?_____		
What was the visit for?_____		
How do you feel about your smile?_____		
Are you interested in whiter teeth?	☐	☐
Are you interested in Replacing teeth?	☐	☐

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 relies on this information when treating me.

_____ _____

Patient Signature Date

_____ _____

Dentist Signature Date