

# Health History Form

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.

## PERSONAL INFORMATION

First Name

Last Name

MI

Home Phone

Cell Phone

Work Phone

Preferred Method of Contact

Phone  Text  Email

E-mail

Mailing Address

City

State

Zip

Date of Birth

Sex

Social Security #

Occupation

Emergency Contact

How did you hear about us?

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

Your Name

Relationship

Home Phone

Cell Phone

**DENTAL INFORMATION** For the following questions mark (x) your responses

Are your teeth sensitive to cold, hot, sweets or pressure?.....  Yes  No

Have you had any periodontal (gum) treatments?.....  Yes  No

Have you ever had orthodontic (braces) treatment?.....  Yes  No

Have you ever had any problems associated with previous dental treatment?.....  Yes  No

Are you currently experiencing dental pain or discomfort?.....  Yes  No

Do you brux or grind your teeth?.....  Yes  No

Do you have sores or ulcers in your mouth?.....  Yes  No

Do you wear dentures or partials?.....  Yes  No

Chief Complaint

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Date of your last exam

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What was done at that time?

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Date of last dental x-rays

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Reason for visit

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## MEDICAL INFORMATION *(Continued)*

**Allergies:** Are you allergic or have you had a reaction to:

	Yes	No		Yes	No
Local anesthetics.....	<input type="checkbox"/>	<input type="checkbox"/>	Latex (rubber).....	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin.....	<input type="checkbox"/>	<input type="checkbox"/>	Food/Other.....	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please specify		
Barbiturates, sedatives, or sleeping pills.....	<input type="checkbox"/>	<input type="checkbox"/>			
Sulfa drugs.....	<input type="checkbox"/>	<input type="checkbox"/>			
Codeine or other narcotics.....	<input type="checkbox"/>	<input type="checkbox"/>			
Metals.....	<input type="checkbox"/>	<input type="checkbox"/>			

Please mark (X) your response if you have or have had any of the following diseases or problems.

	Yes	No		Yes	No		Yes	No		Yes	No
Heart murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion.....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes type I or type II..	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorders.....	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date			Eating disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please specify		
Artificial heart valves.....	<input type="checkbox"/>	<input type="checkbox"/>				Malnutrition.....	<input type="checkbox"/>	<input type="checkbox"/>			
Rheumatic fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia.....	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease...	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent infections.....	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease....	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV infection.....	<input type="checkbox"/>	<input type="checkbox"/>	GE Reflux/persistent heartburn.....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, type of infection		
Angina.....	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis.....	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis.....	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	Persistent swollen glands in neck.....	<input type="checkbox"/>	<input type="checkbox"/>
Coronary artery disease....	<input type="checkbox"/>	<input type="checkbox"/>	Systematic lupus erythematosus.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice, or liver disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Severe headache/migraines..	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves.....	<input type="checkbox"/>	<input type="checkbox"/>	Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	Severe/rapid weight loss...	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack.....	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis.....	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells/seizures....	<input type="checkbox"/>	<input type="checkbox"/>	STDs/STIs.....	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders....	<input type="checkbox"/>	<input type="checkbox"/>			
High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble.....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please specify			ADD.....	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart defects...	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>				ADHD.....	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Chemotherapy/ Radiation treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	Gag Reflex Sensitivity.....	<input type="checkbox"/>	<input type="checkbox"/>			
Rheumatic heart disease...	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain upon exertion..	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder.....	<input type="checkbox"/>	<input type="checkbox"/>			
Abnormal bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain.....	<input type="checkbox"/>	<input type="checkbox"/>						
Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>									

Has a physician recommended that you take antibiotics prior to your treatment?.....  Yes  No

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

If yes, please explain

