Health History Form

Today's Date

As required by law, our office adher maintain. Your answers are for our requestions about your responses to to provide appropriate care for you.	ecords only and whis questionnaire and This office does no	ill be kept conf and there may	idential si be additio	ubject to applicable onal questions conc	laws. Please note	that you will be as	ked some
PERSONAL INFORMA	AHON						
First Name			Last Na	ame			MI
Home Phone	Cell Phone			Work Phone			
Prefered Method of Contact		E-mail					
Phone Text Em	nail						
Mailing Address			City		State	e Zip	1
Walling Address			City		Otate	, <u></u>	,
	Date of Birth		Sex		Social Security	#	
Occupation			Emerge	ency Contact			
· ·			3	,			
How did you hear about us?							
If you are completing this form	m for another p	erson, what	is your	relationship to t	hat 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	Do you brux or grind your teeth?	Yes	No
Have you had any periodontal (gum) treatments?			Do you have sores or ulcers in your mouth?		
Have you ever had orthodontic (braces) treatment?			Do you wear dentures or partials?		
Have you ever had any problems associated with previous dental treatment?			Date of your last exam		
Are you currently experiencing dental pain or discomfort?			What was done at that time?		
Chief Complaint					
			Date of last dental x-rays		
			Reason for visit		

MEDICAL INFORMATION FO	or the following	questio Yes		lease mark (X) your responses. Have you had a serious illness, operation or been hospitalized	Yes	Nο
Are you currently under the care of a physician	?			in the past 5 years?		
Physician Name	Phone			If yes, what was the illness or problem?		
Address/City/State/Zip				Do you take any blood thinners?		
				Do you take aspirin on a regular basis?		
Are you in good health?				Are you taking or have you recently taken any prescription or over the counter medicine(s)?		
Has there been any change in your general heapast year?				If yes, please list all medications, including vitamins, natural or		
If yes, what condition is being treated?				herbal preparations and/or diet supplements:		
,,						
Date of last physical exam						
Do you have a history of chemical dependency	?					
For the following questions mark (x) your respo	nses	Yes	No			
Do you use controlled substances (drugs)?						
Do you use tobacco (smoking, snuff, chew, bid	is)?					
If so, how interested are you in stopping?						
VERY SOMEWHAT NOT INT	ERESTED					
WOMEN ONLY Are you:		Yes	No			
Pregnant?						
Number of weeks						
Taking birth control pills or hormonal replacem	ents?	🔳				
Nursing?		=				
Joint Replacement: Have you ever had an ortho	pedic total ioin	t (hip.	knee.	elbow, finger) replacement?		No
If yes, date If yes, have you If				- · · · · · · · · · · · · · · · · · · ·		
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MEDICAL INFORMATION (Continued)

Allergies: Are you allergic or have you had a reaction to:		Yes	No)				Yes	No		
Local anesthetics				Latex (rubber)							
Aspirin				Food/Other							
Penicillin or other antibiotics				If yes, please specify							
Barbiturates, sedatives, or sleeping pills											
Sulfa drugs											
Codeine or other narcotics											
Metals											
Please mark (X) your response	if you Yes		e or have had any of the followin	ng dise Yes		·	Yes	No		Yes	No
Heart murmur	165	INO	Blood transfusion		IN		165	INO	Mental health disorders	165	INO
Mitral valve prolapse			If yes, date			Eating disorder			If yes, please specify		
Artificial heart valves						Malnutrition					
Rheumatic fever			Hemophilia			Gastrointestinal disease			Recurrent infections		
Cardiovascular disease			AIDS or HIV infection			GE Reflux/persistent			If yes, type of infection		
Angina			Arthritis								
Arteriosclerosis			Autoimmune disease						Kidney problems		
Congestive heart failure			Rheumatoid arthritis						Osteoporosis		
Coronary artery disease			Systematic lupus			Stroke Hepatitis, jaundice, or			Persistent swollen glands in neck		
Damaged heart valves			erythematosus			liver disease			Severe headache/migraines		
Heart attack			Asthma						Severe/rapid weight loss		
Low blood pressure			Bronchitis			9 1			STDs/STIs		
High blood pressure			Emphysema			Neurological disorders			3108/3118		
Congenital heart defects			Sinus trouble			If yes, please specify			ADD		
Pacemaker			Tuberculosis						ADHD		
Rheumatic heart disease			Cancer/Chemotherapy/ Radiation treatment			Gag Reflex Sensitivity			AURU		
Abnormal bleeding			Chest pain upon exertion			Sleep disorder					
Anemia			Chronic pain								
Has a physician recommer	nded t	hat	you take antibiotics prior to	your	trea	atment?				Yes	No
Do you have any disease, condition, or problem not listed above that you think I should know about?											
If yes, please explain											

PHARMACY INFORMATION Pharmacy Name Pharmacy Phone Pharmacy Address **SIGNATURE** 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 doctor and their 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 doctor, or any other member of their 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 All parties involved agree that this document may be signed electronically. The electronic signatures appearing on this document are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility FOR COMPLETION BY OFFICE Comments: