Health History Form

e-mail:_____ Today's date:_____ **Premed**_____
(**Office Use Only**)

Name _____ Home Phone_____ Bus/Cell_____

Address_____city_____ State_____ Zip_____

Occupation_____ DOB_____ Sex: M F Marital Status: S M D W

Emergency Contact _____ Relationship_____ Home Phone_____ Cell _____

How did you hear about our office? _____ If a Pt. referred you here who was it? _____

Dental Information

Do your gums bleed when you brush or floss?	Yes	No	Do you have earaches or neck pain?	Yes	No
Have you had any problems associated with previous dental treatment?	Yes	No	Do you have any clicking, popping, or discomfort in the jaw?	Yes	No
Does food or floss catch between your teeth?	Yes	No	Do you brux or grind your teeth?	Yes	No
Is your mouth dry? Is yes, for how long? _____	Yes	No	Do you have sores or ulcers in your mouth?	Yes	No
Have you had periodontal (gum) treatment?	Yes	No	Do you wear a denture or partial?	Yes	No
Have you had orthodontic treatment?	Yes	No	Are you interested in dental implants?	Yes	No
Do you participate in active recreational activities?	Yes	No	Are you currently experiencing any dental discomfort?	Yes	No
Are your teeth sensitive to cold, hot, sweets, or pressure?	Yes	No	Have you had a serious injury to your head or mouth?	Yes	No

Date of your last dental exam? _____ What was done at that time? _____

What is the reason for your dental visit today? _____

How do you feel about your smile? _____

Have you ever been treated for an allergy or sensitivity to mercury, aluminum, or any other metals? _____

Medical Information

1. Do you have a physician? **Yes No** Physician's Name _____ Phone_____ Last seen _____

2. Have you had a serious illness, operation, or been hospitalized in the past 5 years? **Yes No** If **yes**, please explain:_____

_____

3. What was the date of your last complete physical exam? _____

4. Has there been any change in your general health within the last year? Yes No If **yes**, please explain_____

_____

5. Are you taking or have recently taken any prescription or over-the-counter medicine? Yes No If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements? _____

_____(or attach a copy of your list of medication)

6. Do you use any tobacco products? Y N If so, what is your daily intake? _____ Are you interested in quitting? **Y N**

7. Joint Replacement: **Have you had an orthopedic total joint replacement?** (hip, elbow, knee, finger) **Y N** If yes, date_____

Did you have any complications? _____

8. Are you taking or scheduled to take "bone" bisphosphorates medications: such as alendronate (fosamax), or risedronate (Actonel)? **Y N**

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

Allergies:

Local Anesthetic	Yes	No	Aspirin	Yes	No	Penicillin or other antibiotics	Yes	No
Sulfa Drugs	Yes	No	Codeine or other narcotics	Yes	No	Metals	Yes	No
Latex (rubber)	Yes	No	Iodine	Yes	No	Hay Fever/Seasonal	Yes	No
Animals	Yes	No	Food:	Yes	No	Other: _____		

Please Circle all conditions that apply:

Arthritis	Yes	No	Panic Attack	Yes	No
Rheumatic Fever	Yes	No	Heart Problems	Yes	No
Family History of Heart Problems	Yes	No	Venereal Disease, Herpes II	Yes	No
High blood pressure	Yes	No	Low Blood Pressure	Yes	No
Anemia, Sickle Cell Disease	Yes	No	Pacemaker	Yes	No
Epilepsy, Seizures	Yes	No	Cancer	Yes	No
Fainting Spells	Yes	No	Radiation or Chemical Therapy	Yes	No
Diabetes	Yes	No	Hepatitis	Yes	No
Family History of Diabetes	Yes	No	Ear Infections	Yes	No
Ulcers	Yes	No	Chronic Sinus	Yes	No
Kidney Disorder	Yes	No	Respiratory Problems	Yes	No
Tuberculosis (TB)	Yes	No	Asthma	Yes	No
Enzyme Deficiency	Yes	No	Hemophilia, Bleeding, or Blood Disorder	Yes	No
HIV	Yes	No	Heart Murmur, Mitral Valve Prolapse	Yes	No
Hydrocephalus	Yes	No	Chronic Diarrhea	Yes	No
Anorexia, Bulimia	Yes	No	Chemical Dependency	Yes	No
Contact Lenses	Yes	No	Other eye problems/conditions	Yes	No
Sleep Disorder	Yes	No	Mental Health Disorder	Yes	No

Do you have any disease, condition, or problem not listed above that you think we should know about? Yes No If yes, please explain______

____

I certify that I have read and understand the above and that the information given on this form is accurate to the best of my knowledge.

Signature ____ Date____________________________

Patient Or Guardian Of Minor

_Please DO NOT write below this line. Only signed each visit following today's visit

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