**HEALTH HISTORY FORM**

Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Initial Nickname Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (P.O. Box or Mailing Address) City State Zip code Email

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation Height Weight SS#

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Home Cell Work Patient’s Sex: M \_\_\_\_\_ F\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Relationship Phone

Who may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Dental Information** |  |
| **Yes NO**  Do your gums bleed when you brush? 🞎 🞎  Have you ever had orthodontic (braces) treatment? 🞎 🞎  Are your teeth sensitive to cold, hot, sweets or pressure? 🞎 🞎  Do you have earaches or neck pains? 🞎 🞎  Have you had any periodontal (gum) treatments? 🞎 🞎  Do you wear removable dental appliances? 🞎 🞎  Have you had a serious/difficult problem associated  with any previous dental treatment? 🞎 🞎  If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | How would you describe your current dental problem?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of your last dental exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of last dental x-rays: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  What was done at that time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How do you feel about the appearance of your teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Medical Information** |  |
| **Yes No**  Have you had any of the following diseases or problems?  Active Tuberculosis 🞎 🞎  Persistent cough greater than a 3 week duration 🞎 🞎  Cough that produces blood 🞎 🞎  Are you in good health? 🞎 🞎  Has there been any change in your general  health within the past year? 🞎 🞎  Are you now under the care of a physician? 🞎 🞎  If yes, what is/are the condition(s) being treated?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of last physical examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Physician/s:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Have you had any serious illness, operation, or been hospitalized  in the past 5 years? If yes, what was the illness or problem? 🞎 🞎  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Are you taking or have you recently taken any medicine(s) including  non-prescription medicine? 🞎 🞎  If Yes, what medicine(s) are you taking? Prescribed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Over the counter: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Vitamins, natural or herbal preparations and/or diet supplements:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Yes No**  Are you taking, or have you taken, any diet drugs such as  Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen  (fenfluramine-phentermine combination? 🞎 🞎  Do you drink alcoholic beverages? 🞎 🞎  If yes, how much alcohol did you drink in the last 24 hours? \_\_\_\_\_\_\_  In the past week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Are you alcohol and/or drug dependent? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 🞎  If yes, have you received treatment? (circle one) Yes / No  Do you use drugs or other substances for recreational  purposes? 🞎 🞎  If yes, please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Frequency of use (daily, weekly, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Number of years of recreational drug use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you use tobacco (smoking, snuff, chew)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 🞎  If yes, how interested are you in stopping? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (circle one) Very / Somewhat / Not interested |
| **WOMEN ONLY** |  |
| **Yes No**  Are you or could you be pregnant? 🞎 🞎  Nursing? 🞎 🞎  Taking birth control pills or hormonal replacement? 🞎 🞎 |  |

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| ***Yes No***  Are you allergic to or have you had a reaction to**:**  Local anesthetics 🞎 🞎  Aspirin 🞎 🞎  Penicillin or other antibiotics 🞎 🞎  Barbiturates, sedatives, or sleeping pills 🞎 🞎  Sulfa drugs 🞎 🞎  Codeine or other narcotics 🞎 🞎  Latex 🞎 🞎  Iodine 🞎 🞎  Hay fever/seasonal 🞎 🞎  Animals 🞎 🞎  Food (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Metals (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  To Yes responses, specify type of reaction.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ***Yes No***    Have you had an orthopedic total joint  (hip, knee, elbow, finger) replacement? 🞎 🞎  If yes, when was this operation done? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If you answered Yes to the above question, have you had  any complications or difficulties with your prosthetic joint?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Has a physician or previous dentist recommended that  you take antibiotics prior to your dental treatment? 🞎 🞎  If yes, what antibiotic and dose? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of physician or dentist:  Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **Please (x) a response to indicate if you have or have not had any of the following diseases or problems:** | |
| **Yes No**  Abnormal bleeding \_\_ \_\_  AIDS or HIV infection \_\_ \_\_  Anemia \_\_ \_\_  Arthritis \_\_ \_\_  Rheumatoid arthritis \_\_ \_\_  Asthma \_\_ \_\_  Blood transfusion. If yes, date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Cancer/Chemotherapy/Radiation Treatment \_\_ \_\_  Cardiovascular disease. If yes, specify below: \_\_ \_\_  \_\_\_\_\_ Angina \_\_\_\_\_ Heart murmur  \_\_\_\_\_ Arteriosclerosis \_\_\_\_\_ High blood pressure  \_\_\_\_\_ Artificial heart valves \_\_\_\_\_ Low blood pressure  \_\_\_\_\_ Congenital heart defects \_\_\_\_\_ Mitral valve prolapse  \_\_\_\_\_ Congestive heart failure \_\_\_\_\_ Pacemaker  \_\_\_\_\_Coronary artery disease \_\_\_\_\_ Rheumatic heart disease  \_\_\_\_\_ Damaged heart valves /Rheumatic fever  \_\_\_\_\_ Heart attack  Chest pain upon exertion \_\_ \_\_  Chronic pain \_\_ \_\_  Disease, drug, or radiation-induced immunosuppression \_\_ \_\_  Diabetes. If yes, specify below: \_\_ \_\_  \_\_\_\_ Type I (Insulin dependent) \_\_\_\_\_ Type II  Dry Mouth \_\_ \_\_  Eating disorder. If yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ \_\_  Epilepsy \_\_ \_\_  Fainting spells or seizures \_\_ \_\_  Gastrointestinal disease \_\_ \_\_  G.E. Reflux/persistent heartburn \_\_ \_\_  Glaucoma \_\_ \_\_ | **Yes No**  Hemophilia \_\_ \_\_  Hepatitis, jaundice or liver disease \_\_ \_\_  Recurrent infections \_\_ \_\_  If yes, indicate type of infection: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Kidney problems \_\_ \_\_  Mental health disorders. If yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ \_\_  Malnutrition \_\_ \_\_  Night sweats \_\_ \_\_  Neurological disorders. If yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ \_\_  Osteoporosis \_\_ \_\_  Persistent swollen glands in neck \_\_ \_\_  Respiratory problems. If yes, specify below: \_\_ \_\_  \_\_\_\_\_ Emphysema \_\_\_\_\_ Bronchitis, etc.  Severe headaches/migraine \_\_ \_\_  Severe or rapid weight loss \_\_ \_\_  Sexually transmitted disease \_\_ \_\_  Sinus trouble \_\_ \_\_  Sleep disorder \_\_ \_\_  Sores or ulcers in the mouth \_\_ \_\_  Stroke \_\_ \_\_  Systemic lupus erythematosus \_\_ \_\_  Tuberculosis \_\_ \_\_  Thyroid problems \_\_ \_\_  Ulcers \_\_ \_\_  Excessive urination \_\_ \_\_  Do you have any disease, condition or problem  not listed above that you think I should know about? \_\_ \_\_  Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

I certify that I have read and understand the above. 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