**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 asPondimin (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 recreationalpurposes? 🞎 🞎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 attackChest pain upon exertion \_\_ \_\_Chronic pain \_\_ \_\_Disease, drug, or radiation-induced immunosuppression \_\_ \_\_Diabetes. If yes, specify below: \_\_ \_\_\_\_\_\_ Type I (Insulin dependent) \_\_\_\_\_ Type IIDry 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