HEALTH HISTORY

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PERSONAL INFORMATION

NAME | BIRTH DATE | TODAY'S DATE

ADDRESS | CITY | STATE | ZIP | SS #

EMAIL ADDRESS | PRIMARY PHONE ❑ HOME ❑ CELL ❑ WORK | ALTERNATE PHONE ❑ HOME ❑ CELL ❑ WORK

EMERGENCY CONTACT | RELATIONSHIP | PRIMARY PHONE ❑ HOME ❑ CELL ❑ WORK | ALTERNATE PHONE ❑ HOME ❑ CELL ❑ WORK

OCCUPATION | HEIGHT | WEIGHT | SEX

DO YOU HAVE ANY OF THE FOLLOWING DISEASES OR PROBLEMS? PLEASE CHECK 'IDK' IF YOU DO NOT KNOW THE ANSWER TO THE QUESTION.

	YES	NO	IDK
Active Tuberculosis	❑	❑	❑
Persistent cough greater than a 3 week duration	❑	❑	❑
Cough that produces blood	❑	❑	❑
Been exposed to anyone with tuberculosis	❑	❑	❑

If you answered yes to any of the above, please stop and return this form to the receptionist. Thank you.

DENTAL HISTORY

	YES	NO	IDK
Do your gums bleed when you brush or floss?	❑	❑	❑
Are your teeth sensitive to cold; hot; sweets or pressure?	❑	❑	❑
Is your mouth dry?	❑	❑	❑
Have you had any periodontal (gum) treatments?	❑	❑	❑
Have you ever had orthodontic (braces) treatment?	❑	❑	❑
Have you had any problems associated with previous dental treatment?	❑	❑	❑
Is your home water supply fluoridated?	❑	❑	❑
Do you drink bottled or filtered water?	❑	❑	❑
If yes, how often? Circle One: DAILY WEEKLY OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	❑	❑	❑
What is the reason for your visit today?			
How do you feel about your smile?			

	YES	NO	IDK
Do you have ear aches or neck pain?	❑	❑	❑
Do you have any clicking, popping or discomfort in the jaw?	❑	❑	❑
Do you brux or grind your teeth?	❑	❑	❑
Do you have sores or ulcers in your mouth?	❑	❑	❑
Do you wear dentures or partials?	❑	❑	❑
Do you participate in active recreational activities?	❑	❑	❑
Have you ever had a serious injury to your head or mouth?	❑	❑	❑
What is the date of your last dental exam?			
What was done at that time?			
What is the date of your last dental X-rays?			

MEDICAL HISTORY

	YES	NO	IDK
Are you now under the care of a physician?	❑	❑	❑
Physician Name:			
Physician Phone Number:			
Address / City / State / Zip			
Are you in good health?	❑	❑	❑
Has there been any change in your general health within the past year?	❑	❑	❑
If yes, please explain:			

	YES	NO	IDK
Have you had a serious illness, operation or been hospitalized in the last 5 years?	❑	❑	❑
If yes, please explain:			
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	❑	❑	❑
If yes, please list them below, including vitamins, natural or herbal preparations and dietary supplements:			

OVER ☞

MEDICAL HISTORY

	YES	NO	IDK
Do you wear contact lenses?	❑	❑	❑
Have you had an orthopedic total joint replacement? (*Hip, Knee, Elbow, Finger, Shoulder or Toe)	❑	❑	❑
Any complications? Date of surgery:			
Are you taking or scheduled to begin an antiresorptive agent for osteoporosis or Paget's disease? *(Such as Fosamax, Actone, Atevia, Boniva, Reclast or Prolia)*	❑	❑	❑
Since 2001, were you treated or are you presently scheduled to being treatment with an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myelo-na or metestatic cancer? Date treatment began:	❑	❑	❑

	YES	NO	IDK
Do you use controlled substance? (drugs)	❑	❑	❑
Do you use tobacco? (smoking, e-cigarettes, vape pens, snuff, chew, bidis)	❑	❑	❑
Do you drink alcoholic beverages?	❑	❑	❑
If yes, how much have you drank in the last 24 hours?			
If yes, how much do you drink per week on average?			
WOMEN:			
Are you pregnant? How many weeks?	❑	❑	❑
Nursing?	❑	❑	❑
Taking birth control or a hormonal replacement?	❑	❑	❑

Are you allergic to or have you had a reaction to:	YES	NO	IDK
Local Anesthetics	❑	❑	❑
Aspirin	❑	❑	❑
Penicillin or the antibiotics	❑	❑	❑
Barbiturates, sedatives or sleeping pills	❑	❑	❑
Sulfa Drugs	❑	❑	❑
Codeine or other narcotics	❑	❑	❑

	YES	NO	IDK
Metals	❑	❑	❑
Latex (rubber)	❑	❑	❑
Iodine	❑	❑	❑
Hay Fever / Seasonal	❑	❑	❑
Animals	❑	❑	❑
Food	❑	❑	❑
Other:	❑	❑	❑

	YES	NO	IDK
Artificial (prosthetic) heart valve	❑	❑	❑
Previous infective endocarditis	❑	❑	❑
Damaged valves in transplanted heart	❑	❑	❑
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	❑	❑	❑
Repaired (completely) in the last 6 months	❑	❑	❑
Repaired CHD with residual defects	❑	❑	❑

	YES	NO	IDK
Cardiovascular Disease	❑	❑	❑
Angina	❑	❑	❑
Arteriosclerosis	❑	❑	❑
Congestive Heart Failure	❑	❑	❑
Damaged Heart Valves	❑	❑	❑
Heart Attack	❑	❑	❑
Heart Murmur	❑	❑	❑
Low blood pressure	❑	❑	❑
High blood pressure	❑	❑	❑
Other heart defects	❑	❑	❑

	YES	NO	IDK
Mitral valve prolapse	❑	❑	❑
Pacemaker	❑	❑	❑
Rheumatic Fever	❑	❑	❑
Rheumatic Heart disease	❑	❑	❑
Abnormal bleeding	❑	❑	❑
Anemia	❑	❑	❑
Blood transfusion / DATE:	❑	❑	❑
Hemophilia	❑	❑	❑
AIDS or HIV infection	❑	❑	❑
Arthritis	❑	❑	❑

	YES	NO	IDK
Autoimmune disease	❑	❑	❑
Rheumatoid arthritis	❑	❑	❑
Systemic lupus erythematosus	❑	❑	❑
Asthma	❑	❑	❑
Bronchitis	❑	❑	❑
Emphysema	❑	❑	❑
Sinus trouble	❑	❑	❑
Tuberculosis	❑	❑	❑
Cancer/Chemo/Radiation	❑	❑	❑
Chest pain with exertion	❑	❑	❑
Chronic pain	❑	❑	❑
Diabetes Type I or II	❑	❑	❑
Eating Disorder	❑	❑	❑
Malnutrition	❑	❑	❑
Gastrointestinal disease	❑	❑	❑
G.E. Reflux / heartburn	❑	❑	❑
Ulcers	❑	❑	❑
Thyroid problems	❑	❑	❑
Stroke	❑	❑	❑

	YES	NO	IDK
Glaucoma	❑	❑	❑
Hepatitis, jaundice or liver disease	❑	❑	❑
Epilepsy	❑	❑	❑
Fainting spells or seizures	❑	❑	❑
Neurological disorders	❑	❑	❑
Please specify:			
Sleep Disorder	❑	❑	❑
Have you been told you snore?	❑	❑	❑
Mental Health disorders	❑	❑	❑
Please specify:			
Recurrent Infections Please specify:	❑	❑	❑
Kidney problems	❑	❑	❑
Night Sweats	❑	❑	❑
Osteoporosis	❑	❑	❑
Persistent swollen glands in the neck	❑	❑	❑
Severe headaches/migraines	❑	❑	❑
Severe or rapid weight loss	❑	❑	❑
Sexually transmitted disease	❑	❑	❑
Excessive urination	❑	❑	❑

Has a physician or previous dentist recommended that you antibiotics prior to your dental treatment? ❑ ❑ ❑

Name of physician or dentist making recommendation: Phone:

Do you have any disease, condition or problem not listed above that you feel we should know about? Please explain:

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 dentist and staff will reply 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 dentist or any member of staff responsible for any action they rake or do not take due to errors or omissions that I may have made in the completion of this form.

Signature of Patient / Legal Guardian **Date:**

Signature of Dentist **Date:**

Dentist Notes: