# Health History Form

E-mail: Today's Date: Language Preference:

As required by law, our office adheres to written policies to protect the privacy on information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

## *Patient Information*

*SS#/SIN* _____

*Name* _____ *Birthdate* _____ *Home Phone* _____

*Address* _____ *City* _____ *State*_____ *Zip* _____

*Cell Phone* _____

*Check Appropriate Box:* ☐ *Minor* ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Separated*

*If Student, Name of School/College* _____ *City* _____ *State*_____ *Zip*

*Patient or Parent/Guardian's Employer* _____ *Work Phone* _____

*Business Address* _____ *City* _____ *State*_____ *Zip* _____

*Spouse or Parent/Guardian's Name* _____ *Employer* _____ *Work Phone* _____

*Whom May We Thank for Referring You?* _____

*Person to Contact in Case of Emergency* _____ *Phone* _____

## *Responsible Party*

*Name of Person Responsible for this Account* _____ *Relationship to Patient* _____

*Address* _____ *Home Phone* _____

*Email* _____ *Cell Phone* _____

*Driver's License #* _____ *Birthdate* _____

*Employer* _____ *Work Phone* _____ *SS#/SIN* _____

*Is this Person Currently a Patient on our Office?* ☐ *Yes* ☐ *No*

## *Insurance Information*

*Name of Insured* _____ *Relationship to Patient* _____

*Birthdate* _____ *SS#/SIN* _____

*Name of Employer* _____ *Union or Local #* _____ *Work Phone* _____

*Insurance Company* _____ *Group #* _____ *Policy/ID#* _____

*Ins. Co. Address* _____ *City* _____ *State*_____ *Zip* _____

## *Secondary Dental Insurance*

*Name of Insured* _____ *Relationship to Patient* _____

*Birthdate* _____ *SS#/SIN* _____

*Name of Employer* _____ *Union or Local #* _____ *Work Phone* _____

*Insurance Company* _____ *Group #* _____ *Policy/ID#* _____

*Ins. Co. Address* _____ *City* _____ *State*_____ *Zip* _____

## *Medical Insurance*

*Name of Insured* _____ *Relationship to Patient* _____

*Birthdate* _____ *SS#/SIN* _____

*Name of Employer* _____ *Union or Local #* _____ *Work Phone* _____

*Insurance Company* _____ *Group #* _____ *Policy/ID#* _____

*Ins. Co. Address* _____ *City* _____ *State*_____ *Zip* _____

# Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

| *(Check DK if you Don't Know the answer to the question)* | Yes | No | DK |
|---|---|---|---|
| Do you wear contact lenses? | ☐ | ☐ | ☐ |
| **Joint Replacement.** Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? | ☐ | ☐ | ☐ |
| Date:_____ If yes, have you had any complications?_____ | | | |
| Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamex®) or risedronate (Actonel®) for osteoporosis or Paget's disease? | ☐ | ☐ | ☐ |
| Since 2001, were you treated or are you presently scheduled to begin treatment with intravenous bisphosphonates (Aredis® or Zomets®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? | ☐ | ☐ | ☐ |
| Date Treatment began: _____ | | | |

| | Yes | No | DK |
|---|---|---|---|
| Do you use controlled substances (drugs) | ☐ | ☐ | ☐ |
| Do you use tobacco (smoking, snuff, chew, bidis)? | ☐ | ☐ | ☐ |
| If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED | | | |
| Do you drink alcoholic beverages? | ☐ | ☐ | ☐ |
| If yes, how much alcohol did you drink in the last 24 hours? _____ | | | |
| If yes, how much do you typically drink in a week? _____ | | | |
| **WOMEN ONLY** Are you: | | | |
| Pregnant? | ☐ | ☐ | ☐ |
| Number of weeks: _____ | | | |
| Taking birth control pills or hormonal replacement? | ☐ | ☐ | ☐ |
| Nursing? | ☐ | ☐ | ☐ |

| **Allergies** - Are you allergic to or have you had a reaction to: To all yes responses, specify the reaction. | Yes | No | DK |
|---|---|---|---|
| Local anesthetics _____ | ☐ | ☐ | ☐ |
| Aspirin _____ | ☐ | ☐ | ☐ |
| Penicillin or other antibiotics _____ | ☐ | ☐ | ☐ |
| Barbiturates, sedatives, or sleeping pills _____ | ☐ | ☐ | ☐ |
| Sulfa drugs _____ | ☐ | ☐ | ☐ |
| Codeine or other narcotics _____ | ☐ | ☐ | ☐ |

| | Yes | No | DK |
|---|---|---|---|
| Metals _____ | ☐ | ☐ | ☐ |
| Latex (rubber) _____ | ☐ | ☐ | ☐ |
| Iodine _____ | ☐ | ☐ | ☐ |
| Hay fever/seasonal _____ | ☐ | ☐ | ☐ |
| Animals _____ | ☐ | ☐ | ☐ |
| Food _____ | ☐ | ☐ | ☐ |
| Other _____ | ☐ | ☐ | ☐ |

***Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.***

| | Yes | No | DK |
|---|---|---|---|
| Artificial (prosthetic) heart valve | ☐ | ☐ | ☐ |
| Previous infective endocarditis | ☐ | ☐ | ☐ |
| Damaged valves in transplanted heart | ☐ | ☐ | ☐ |
| Congenital heart disease (CHD) | | | |
| Unrepaired, cyanotic CDH | ☐ | ☐ | ☐ |
| Repaired (completely) in last 6 months | ☐ | ☐ | ☐ |
| Repaired CHD with residual defects | ☐ | ☐ | ☐ |

*Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.*

| | Yes | No | DK |
|---|---|---|---|
| Cardiovascular disease | ☐ | ☐ | ☐ |
| Angina | ☐ | ☐ | ☐ |
| Arteriosclerosis | ☐ | ☐ | ☐ |
| Congestive heart failure | ☐ | ☐ | ☐ |
| Damaged heart valves | ☐ | ☐ | ☐ |
| Heart attack | ☐ | ☐ | ☐ |
| Heart murmur | ☐ | ☐ | ☐ |
| Low blood pressure | ☐ | ☐ | ☐ |
| High blood pressure | ☐ | ☐ | ☐ |
| Other congenital heart defects | ☐ | ☐ | ☐ |
| Mitral valve prolapse | ☐ | ☐ | ☐ |
| Pacemaker | ☐ | ☐ | ☐ |
| Rheumatic fever | ☐ | ☐ | ☐ |
| Rheumatic heart disease | ☐ | ☐ | ☐ |
| Abnormal bleeding | ☐ | ☐ | ☐ |
| Anemia | ☐ | ☐ | ☐ |
| Blood transfusion | ☐ | ☐ | ☐ |
| If yes, date:_____ | | | |
| Hemophilia | ☐ | ☐ | ☐ |
| AIDS or HIV infection | ☐ | ☐ | ☐ |
| Arthritis | ☐ | ☐ | ☐ |

| | Yes | No | DK |
|---|---|---|---|
| Autoimmune disease | ☐ | ☐ | ☐ |
| Rheumatoid arthritis | ☐ | ☐ | ☐ |
| Systemic lupus erythematosus | ☐ | ☐ | ☐ |
| Asthma | ☐ | ☐ | ☐ |
| Bronchitis | ☐ | ☐ | ☐ |
| Emphysema | ☐ | ☐ | ☐ |
| Sinus trouble | ☐ | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ | ☐ |
| Cancer/Chemotherapy/ Radiation Treatment | ☐ | ☐ | ☐ |
| Chest pain upon exertion | ☐ | ☐ | ☐ |
| Chronic pain | ☐ | ☐ | ☐ |
| Diabetes Type I or II | ☐ | ☐ | ☐ |
| Eating disorder | ☐ | ☐ | ☐ |
| Malnutrition | ☐ | ☐ | ☐ |
| Gastrointestinal disease | ☐ | ☐ | ☐ |
| G.E. Reflux/persistent heartburn | ☐ | ☐ | ☐ |
| Ulcers | ☐ | ☐ | ☐ |
| Thyroid problems | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ |
| Glaucoma | ☐ | ☐ | ☐ |

| | Yes | No | DK |
|---|---|---|---|
| Hepatitis, jaundice or liver disease | ☐ | ☐ | ☐ |
| Epilepsy | ☐ | ☐ | ☐ |
| Fainting spells or seizures | ☐ | ☐ | ☐ |
| Neurological disorders | ☐ | ☐ | ☐ |
| If yes, specify:_____ | | | |
| Sleep disorder | ☐ | ☐ | ☐ |
| Do you snore? | ☐ | ☐ | ☐ |
| Mental health disorders | ☐ | ☐ | ☐ |
| Specify:_____ | | | |
| Recurrent Infections | ☐ | ☐ | ☐ |
| Type of infection:_____ | | | |
| Kidney problems | ☐ | ☐ | ☐ |
| Night sweats | ☐ | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ | ☐ |
| Persistent swollen glands in neck | ☐ | ☐ | ☐ |
| Severe headaches/ migraines | ☐ | ☐ | ☐ |
| Severe or rapid weight loss | ☐ | ☐ | ☐ |
| Sexually transmitted disease | ☐ | ☐ | ☐ |
| Excessive urination | ☐ | ☐ | ☐ |

| | Yes | No | DK |
|---|---|---|---|
| Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? | ☐ | ☐ | ☐ |

Name of physician or dentist making recommendation: | Phone:

Please list any medications you are taking:

**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 his/her 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 dentist, or any other member of his/her staff, responsible for any action taken or do not take because of errors or omission that I may have made in the completion of this form.

Signature of patient/Legal Guardian: | Print Name: | Date:

## FOR COMPLETION BY DENTIST

Comments: _____

Signature_____ Date_____