

## Health History Form      Name \_\_\_\_\_ Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems or medications could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

### Medical Information

Are you now under the care of a physician? If yes, explain \_\_\_\_\_

Physician's name or Medical facility: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

Have you had a serious illness, operation or been hospitalized in the past 5 years? If yes, please explain \_\_\_\_\_

Please list all prescription medications, supplements (including herbal), and over the counter medications you are taking:

### Allergies have you had an allergic reaction to any of the following:

	Yes	No		Yes	No
Local anesthetics .....	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin .....	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics .....	<input type="checkbox"/>	<input type="checkbox"/>	Barbituates or sleeping pills .....	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs .....	<input type="checkbox"/>	<input type="checkbox"/>	Codeine or other narcotics .....	<input type="checkbox"/>	<input type="checkbox"/>
Metals .....	<input type="checkbox"/>	<input type="checkbox"/>	Latex .....	<input type="checkbox"/>	<input type="checkbox"/>

Other allergies: \_\_\_\_\_

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

	Yes	No		Yes	No
Joint replacement: Have you had a total joint (knee, hip, elbow, finger) replaced? .....	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, Date: _____			High blood pressure .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you taken alendronate (Fosamax), risedronate (Actonel), or ibandronate (Boniva) for osteoporosis or paget's disease? .....	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal bleeding .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you taken intravenous bisphosphonates like Aredia or zoledronic acid (Reclast)? .....	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia .....	<input type="checkbox"/>	<input type="checkbox"/>
Date began treatment: _____			AIDS or HIV infection .....	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve .....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis .....	<input type="checkbox"/>	<input type="checkbox"/>
Previous infective endocarditis .....	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice, liver disease, or liver problems .....	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves in transplanted heart .....	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease (CHD) .....	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis .....	<input type="checkbox"/>	<input type="checkbox"/>
Unrepaired cyanotic CHD .....	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Repaired (completely) in last 6 mo. ....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>
Repaired CHD with residual defects ...	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus Erythematosus .....	<input type="checkbox"/>	<input type="checkbox"/>
Other congenital heart defects .....	<input type="checkbox"/>	<input type="checkbox"/>	Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse .....	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis .....	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema .....	<input type="checkbox"/>	<input type="checkbox"/>
Angina .....	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble .....	<input type="checkbox"/>	<input type="checkbox"/>
Atherosclerosis .....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis .....	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure .....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Chemotherapy .....	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves .....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, type and date: _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart Bypass .....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatment .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack .....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, date: _____			Diabetes Type II .....	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain .....	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur .....	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker .....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems .....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever .....	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers .....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic heart disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease .....	<input type="checkbox"/>	<input type="checkbox"/>
			Stroke .....	<input type="checkbox"/>	<input type="checkbox"/>
			Difficulty hearing/Deaf .....	<input type="checkbox"/>	<input type="checkbox"/>
			Visually impaired/Blind .....	<input type="checkbox"/>	<input type="checkbox"/>
			Glaucoma .....	<input type="checkbox"/>	<input type="checkbox"/>
			Epilepsy .....	<input type="checkbox"/>	<input type="checkbox"/>
			Fainting spells or seizures .....	<input type="checkbox"/>	<input type="checkbox"/>

Neurological disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you use controlled substances (street drugs)?	<input type="checkbox"/>	<input type="checkbox"/>
Mental health disorders .....	<input type="checkbox"/>	<input type="checkbox"/>	Do you use tobacco (smoking, snuff, chew, bidis)?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>		
Attention Deficit Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<b>WOMEN ONLY</b>		
Severe headaches/migraines .....	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant? If yes, number of weeks __	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea .....	<input type="checkbox"/>	<input type="checkbox"/>	Nursing? .....	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion.....	<input type="checkbox"/>	<input type="checkbox"/>			

**Dental Information** For the following questions, please mark (X) your responses to the following questions:

Do your gums bleed when you brush or floss? .....	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to hot, cold, sweets or pressure? .....	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had periodontal (gum) treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatments?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had problems associated with previous dental treatment? .....	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently experiencing dental discomfort?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any clicking, popping, or discomfort of the jaw? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you grind or clench your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear dentures or partials? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a serious injury to your head or mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>
Date of your last dental exam: _____		
What is your reason for your visit to the dentist today? _____		

How do you feel about your smile? \_\_\_\_\_

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

Signature of patient/legal guardian: \_\_\_\_\_ Date: \_\_\_\_\_

DDS/RDH Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Medical History Update**

Have there been any changes in your health since your last dental appointment?  Yes  No

For what conditions? \_\_\_\_\_

Are you taking any new medications?  Yes  No If yes, what? \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

DDS/RDH Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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