# HEALTH HISTORY FORM

Today's Date: ______________________ E-Mail: ________________________________________

Patient Name: _____________________________________ Preferred Name: __________________________

Date of Birth: _____/_____/_____ (MM/DD/YYYY) Social Security No.: _______________________

Cell Phone: _____________________ Home Phone: ___________________ Business Phone: _________________

Address: ______________________________________________________________________________________
City/State Zip Code

Family Status: ____ Married ____ Single ____ Child ____ Other

Emergency Contact: ____________________________________________________________________________
Name Relationship Phone #

Are you completing this form for someone else? YES NO If yes, what is your relationship: __________________

## COMMUNICATION

| | | |
|---|---|---|
| Would you like to receive dental appointment reminders by text and/or e-mail? | YES | NO |
| May we leave personal/medical/billing information on your voicemail/answering machine? | YES | NO |
| May we call you on your home/cell phone regarding personal/medical/billing information? | YES | NO |

Do you have any of the following diseases or problems: (DK = Don't Know answer to question)
- Active Tuberculosis? ____ (Y/N/DK)
- Persistent cough great than 3 weeks? ____ (Y/N/DK)
- Cough that produces blood? ____ (Y/N/DK)
- Been exposed to anyone with Tuberculosis? ____ (Y/N/DK)

***If you've answered YES to any of the above questions, please stop and return to the Front Desk.***

## Dental Information (Y / N / DK)

Do your gums bleed? ___

Are your teeth sensitive to: Hot? ___ Cold? ___ Sweets? ___ Pressure? ___

Is your mouth dry? ___

Have you had periodontal (gum) treatments? ___

Have you had orthodontic treatment? ___

Have you had problems associated with past dental treatments? ___

Is your home water supply fluoridated? ___

Do you drink bottled or filtered water? ___
If yes, how often? Daily/Weekly/Occasionally

Are you currently experiencing dental pain or discomfort? ___

Do you have earaches or neck pain? ___

Do you have clicking/popping, or jaw discomfort? ___

Do you grind/clench your teeth? ___

Do you have ulcers or sores in your mouth? ___

Do you wear dentures? ___ Partials? ___

Do you participate in recreational activities? ___
If yes, do you wear a mouthguard? ___

Have you had a serious injury to your head or mouth? __

Approx. date of last dental cleaning: __________

Approx. date of last dental x-rays: ________

How do you feel about your smile? __________________

**Medical Information**

Are you in good health? YES NO
Have you had changes in your general health within the past year? YES NO
If yes, what condition is being treated?

Are you under the care of a physician? YES NO
Physician Name:

Phone:

Date of last physical exam?

Are you taking, or recently have taken any prescription or over the counter medicine(s)?

Are you, or have you taken, any diet drugs such as Pondimin (fenflluramine), Redux (dexphenfluramine), or phen-fen (fenflluramine-phentermine combination)? ___
Please specify: ____________________________

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosomax®) 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 (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?
Date to begin treatment: __________________

Have you had a serious illness, operation or been hospitalized in the past 5 years?

If yes, what was the illness/problem?
_________________________________________
_________________________________________
_________________________________________

Please list all medications, including vitamins (natural/herbal) and/or diet supplements:
_________________________________________
_________________________________________
_________________________________________
_________________________________________
*Please provide a list if there is not enough space

Do you drink alcoholic beverages? YES NO

How much in last 24 hours? ______________
How much in a typical week? ____________

Do you use tobacco (smoking, snuff, chew, bidis)?
If so, are you interested in stopping? ___

Do you use any type of e-cigarette? ___

Do you use controlled substances (drugs) for recreational purpose? ___

WOMEN ONLY

Are you pregnant? _____
Number of weeks: _____

Are you nursing? ______

Are you taking birth control or hormone replacement? ______

**ALLERGIES**

Latex ----------------------------------------Y N DK
Penicillin ------------------------------------Y N DK
Other antibiotics ----------------------------Y N DK
Local anesthetics ---------------------------Y N DK
Sulfa drugs ----------------------------------Y N DK
Aspirin ---------------------------------------Y N DK
Codeine --------------------------------------Y N DK
Other narcotics -----------------------------Y N DK
Barbiturates, sedatives, or sleeping pills -Y N DK
Metals ---------------------------------------Y N DK
Iodine ----------------------------------------Y N DK
Hay fever/seasonal -------------------------Y N DK
Animals -------------------------------------Y N DK
Food ----------------------------------------Y N DK
Other: ___________________________________

Medical Information (Cont.)

| | | |
|---|---|---|
| Angina: Y / N / DK | Rheumatic heart disease: Y / N / DK | Emphysema: Y / N / DK |
| Anemia: Y / N / DK | Low blood pressure: Y / N / DK | Epilepsy: Y / N / DK |
| Pacemaker: Y / N / DK | High blood pressure: Y / N / DK | Sinus trouble: Y / N / DK |
| Arteriosclerosis: Y / N / DK | Stroke: Y / N / DK | Kidney problems: Y / N / DK |
| Blood transfusion: Y / N / DK | Coronary artery disease: Y / N / DK | Diabetes (Type I or II) Y / N / DK |
| Chest pain upon exertion: Y / N / DK | Congenital heart defects: Y / N / DK | Chronic Pain: Y / N / DK |
| Mitral valve prolapse: Y / N / DK | Fainting spells: Y / N / DK | Sexually Trans. Disease: Y / N / DK |
| Abnormal bleeding: Y / N / DK | Seizures: Y / N / DK | HIV / AIDS: Y / N / DK |
| Artificial heart valve: Y / N / DK | Osteoporosis: Y / N / DK | Hepatitis: Y / N / DK |
| Heart attack: Y / N / DK | Asthma: Y / N / DK | HPV: Y / N / DK |
| Cardiovascular disease: Y / N / DK | Thyroid problems: Y / N / DK | Ulcers: Y / N / DK |
| Congestive heart failure: Y / N / DK | Arthritis: Y / N / DK | Sleep apnea: Y / N / DK |
| Heart Murmur: Y / N / DK | Bronchitis: Y / N / DK | Rheumatoid arthritis: Y / N / DK |
| Hemophilia: Y / N / DK | Glaucoma: Y / N / DK | ADHD: Y / N / DK |
| Persistent swollen glands in neck: Y / N / DK | Autoimmune disease: Y / N / DK | Severe headaches or migraines: Y / N / DK |
| Mental Disorders: (circle all that apply) Anxiety, Bipolar, Depression, Eating disorders, Schizophrenia, Alcohol/Substance abuse/addiction | Recurrent infections: Specify: | Neurological disorders: Specify: |

Has a physician or dentist recommended taking antibiotics before dental treatment? YES NO

Have you had a **JOINT** replacement? Y / N If yes, what joints, and when? ______________________________

Were you told to take an antibiotic before dental appts? ___ Have you had related complications? ___

Have you had a **HEART VALVE** replacement? Y / N If yes, when? ______________________________

Were you told to take an antibiotic before dental appts? ___ Have you had related complications? ___

What is the name of your Orthopedic Surgeon or Cardiologist? ______________________________

Do you have any other disease, condition, or problem not listed that we should know about? Y / N

If yes, please explain: ______________________________

*Note: both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.*

**We make every effort to be extremely gentle, caring and patient to put you at ease and address your apprehensions. If you have concerns about dental fears and anxieties, feel free to speak with Dr. Jones personally so that we can work through it together.**

| My dental anxiety/fear level is: | 1 | 5 | 10 |
|---|---|---|---|
| | **LOW** | **MODERATE** | **HIGH** |

I certify that I have read and understand the above, and the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and 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 member of 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.

______________________________ ______________________________

Patient/Guardian Signature Date