HEALTH HISTORY FORM

Patient Name: ______________________________ DOB: ______________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dental treatment you will receive. Please read the following questions carefully and answer each to the best of your knowledge.

Question	YES	NO	If yes
Are you under a physician's care now? If yes, please explain.	☐ YES	☐ NO	If yes:
Have you been hospitalized, had a serious illness or operation in the past 5 years? If yes, please explain.	☐ YES	☐ NO	If yes:
Have you ever had a serious injury to your head or neck or mouth? If yes, please explain.	☐ YES	☐ NO	If yes:
Are you currently taking any prescription or over the counter medicine(s)? If yes, please list all.	☐ YES	☐ NO	If yes:
Have you ever had an orthopedic total joint (knee/hip/elbow) replacement? If yes, please explain.	☐ YES	☐ NO	If yes:
Have you ever taken an antiresorptive agent for osteoporosis or Paget's Disease?	☐ YES	☐ NO	If yes:
Have you ever taken Fen-Phen, Redux, or any other weight loss drugs? If yes, please list all.	☐ YES	☐ NO	If yes:
Are you currently experiencing any dental pain or discomfort? If yes, please explain.	☐ YES	☐ NO	If yes:
Have you had any problems associated with previous dental treatment? If yes, please explain.	☐ YES	☐ NO	If yes:
Would you consider yourself a "dentaphobe" or a high fear patient?	☐ YES	☐ NO	

WOMEN: ARE YOU…

Pregnant/Trying to get pregnant? ☐YES ☐NO	Nursing? ☐YES ☐NO	Taking Oral Contraceptives/Birth control? ☐YES ☐NO

PLEASE MARK (X) YOUR RESPONSE TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS BELOW:

☐Artificial (prosthetic) heart valve ☐Previous Infective Endocarditis ☐Damaged Valves ☐Congenital Heart Disease (CHD)
☐Unrepaired, Cyanotic CHD ☐CHD Repaired in the last 6 months ☐Repaired CHD with residual Defects ☐None of these conditions apply to me

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO: (TO ALL YES, PLEASE SPECIFY TYPE OF REACTION IN COMMENTS SECTION OR ON BACK OF PAGE)

☐Aspirin ☐Barbiturates, sedatives or sleeping pills ☐Codeine or other narcotics ☐Latex
☐Local Anesthetics ☐Metal If yes, type: ______________ ☐Penicillin or other antibiotics ☐Sulfa Drugs
☐Other Allergy not listed above: ______________________________ ☐No Known Drug Allergies

DO YOU HAVE, OR HAVE HAD, ANY OF THE FOLLOWING? (PLEASE MARK (X) EACH ANSWER INDIVIDUALLY AS YES OR NO)

Condition		Condition		Condition		Condition	
AIDS/HIV	☐YES/NO☐	Alzheimer's Disease	☐YES/NO☐	Anaphylaxis	☐YES/NO☐	Anemia	☐YES/NO☐
Angina	☐YES/NO☐	Arthritis/Gout	☐YES/NO☐	Arrhythmia	☐YES/NO☐	Asthma	☐YES/NO☐
Autoimmune Disease	☐YES/NO☐	Blood Disease	☐YES/NO☐	Blood Transfusion	☐YES/NO☐	Bruise Easily	☐YES/NO☐
Cancer/Leukemia	☐YES/NO☐	Chemotherapy/Radiation	☐YES/NO☐	Chest Pains	☐YES/NO☐	COPD/Emphysema	☐YES/NO☐
Cortisone Medicine	☐YES/NO☐	Diabetes	☐YES/NO☐	Chronic Pain	☐YES/NO☐	Eating Disorder/Malnutrition	☐YES/NO☐
Epilepsy/Seizures	☐YES/NO☐	Excessive Bleeding	☐YES/NO☐	Excessive Thirst	☐YES/NO☐	Fainting Spells/Dizziness	☐YES/NO☐
Frequent Diarrhea	☐YES/NO☐	Glaucoma	☐YES/NO☐	Hay Fever	☐YES/NO☐	Heart Attack/Failure	☐YES/NO☐
Heart Murmur	☐YES/NO☐	Heart Pacemaker	☐YES/NO☐	Heart Disease/Trouble	☐YES/NO☐	Hemophilia	☐YES/NO☐
Hepatitis:(Circle one: A/B/C)	☐YES/NO☐	Herpes/Cold Sores	☐YES/NO☐	High Blood Pressure	☐YES/NO☐	High Cholesterol	☐YES/NO☐
Hives / Rash	☐YES/NO☐	Hypoglycemia	☐YES/NO☐	Jaundice	☐YES/NO☐	Kidney Problems/Stones	☐YES/NO☐
Liver Disease/Lupus	☐YES/NO☐	Low Blood Pressure	☐YES/NO☐	Lung Disease	☐YES/NO☐	Migraines	☐YES/NO☐
Neurological Disorder	☐YES/NO☐	Osteoporosis	☐YES/NO☐	Pain In Jaw Joints	☐YES/NO☐	Parathyroid Disease	☐YES/NO☐
Psychiatric Care	☐YES/NO☐	Rapid/Severe Weight Loss	☐YES/NO☐	Recurrent Infections (Please Explain)	☐YES/NO☐	Renal Dialysis	☐YES/NO☐
Rheumatic/Scarlet Fever	☐YES/NO☐	Rheumatism	☐YES/NO☐	Shingles	☐YES/NO☐	Sickle Cell Disease	☐YES/NO☐
Sinus/Breathing Problems	☐YES/NO☐	Sleep Disorder/Snoring	☐YES/NO☐	Spina Bifida	☐YES/NO☐	Stomach/Intestinal Disease	☐YES/NO☐
Stroke	☐YES/NO☐	Swelling of Limbs	☐YES/NO☐	Thyroid Disease	☐YES/NO☐	Tonsillitis	☐YES/NO☐
Tuberculosis	☐YES/NO☐	Tumors or Growths	☐YES/NO☐	Ulcers	☐YES/NO☐	Use of Controlled Substances	☐YES/NO☐
Use Tobacco: Packs/week: ______	☐YES/NO☐	Venereal Disease (STD)	☐YES/NO☐	Any Disease, Problem, or Condition not listed above?	☐YES/NO☐	If Yes, Please Explain: ______________	

COMMENTS: ____

____

______________________________ **BASELINE VITALS:** BP: ______ / ______ P: ______

Note: Both the doctor and patient are encouraged to discuss any and all relevant 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 to the best of my knowledge. I understand the importance of a truthful health history and that my dentists and their staff will rely on this information when 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 staff member, responsible for any action they may take because of errors or omissions that I may have made in the completion of this form. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE: ______________________________ **DATE:** ______________