ADA American Dental Association
www.ada.org

| Medical Alert: | Condition: | Premedication: | Allergies: | Anesthesia: | Date: |
|---|---|---|---|---|---|
| | | | | | |

# HEALTH HISTORY FORM

Name: Home Phone: ( ) Business Phone: ( )
LAST FIRST MIDDLE

Address: City: State: Zip Code:
P.O. BOX or Mailing Address

Occupation: Height: Weight: Date of Birth: Sex: M ❑ F ❑

SS#: Emergency Contact: Relationship: Phone: ( )

If you are completing this form for another person, what is your relationship to that person?
NAME RELATIONSHIP

**For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit 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.**

## DENTAL INFORMATION

| | Yes | No | Don't Know |
|---|---|---|---|
| Do your gums bleed when you brush? | ❑ | ❑ | ❑ |
| Have you ever had orthodontic (braces) treatment? | ❑ | ❑ | ❑ |
| Are your teeth sensitive to cold, hot, sweets or pressure? | ❑ | ❑ | ❑ |
| Do you have earaches or neck pains? | ❑ | ❑ | ❑ |
| Have you had any periodontal (gum) treatments? | ❑ | ❑ | ❑ |
| Do you wear removable dental appliances? | ❑ | ❑ | ❑ |
| Have you had a serious/difficult problem associated with any previous dental treatment? | ❑ | ❑ | ❑ |

If yes, explain:

How would you describe your current dental problem?

Date of your last dental exam:

Date of last dental x-rays:

What was done at that time?

How do you feel about the appearance of your teeth?

## MEDICAL INFORMATION

| | Yes | No | Don't Know |
|---|---|---|---|
| **If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.** | | | |
| Have you had any of the following diseases or problems? | | | |
| Active Tuberculosis | ❑ | ❑ | ❑ |
| Persistent cough greater than a 3 week duration | ❑ | ❑ | ❑ |
| Cough that produces blood | ❑ | ❑ | ❑ |
| Are you in good health? | ❑ | ❑ | ❑ |
| Has there been any change in your general health within the past year? | ❑ | ❑ | ❑ |
| Are you now under the care of a physician? | ❑ | ❑ | ❑ |

If yes, what is/are the condition(s) being treated?

Date of last physical examination:

Physician:
NAME PHONE

ADDRESS CITY/STATE ZIP

NAME PHONE

ADDRESS CITY/STATE ZIP

| | Yes | No | Don't Know |
|---|---|---|---|
| Have you had any serious illness, operation, or been hospitalized in the past 5 years? | ❑ | ❑ | ❑ |

If yes, what was the illness or problem?

| | Yes | No | Don't Know |
|---|---|---|---|
| Are you taking or have you recently taken any medicine(s) including non-prescription medicine? | ❑ | ❑ | ❑ |

If yes, what medicine(s) are you taking?

Prescribed:

Over the counter:

Vitamins, natural or herbal preparations and/or diet supplements:

| | Yes | No | Don't Know |
|---|---|---|---|
| Are you taking, or have you taken, any diet drugs such Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)? | ❑ | ❑ | ❑ |
| Do you drink alcoholic beverages? | ❑ | ❑ | ❑ |

If yes, how much alcohol did you drink in the last 24 hours?

In the past week?

| | Yes | No | Don't Know |
|---|---|---|---|
| Are you alcohol and/or drug dependent? | ❑ | ❑ | ❑ |

If yes, have you received treatment? (circle one) Yes / No

| | Yes | No | Don't Know |
|---|---|---|---|
| Do you use drugs or other substances for recreational purposes? | ❑ | ❑ | ❑ |

If yes, please list:

Frequency of use (daily, weekly, etc.):

Number of years of recreational drug use:

| | Yes | No | Don't Know |
|---|---|---|---|
| Do you use tobacco (smoking, snuff, chew)? | ❑ | ❑ | ❑ |

If yes, how interested are you in stopping?
(circle one) Very / Somewhat / Not interested

| | Yes | No | Don't Know |
|---|---|---|---|
| Do you wear contact lenses? | ❑ | ❑ | ❑ |

**PLEASE COMPLETE BOTH SIDES**

| Are you allergic to or have you had a reaction to? | Yes | No | Don't Know |
|---|---|---|---|
| Local anesthetics | ❑ | ❑ | ❑ |
| Aspirin | ❑ | ❑ | ❑ |
| Penicillin or other antibiotics | ❑ | ❑ | ❑ |
| Barbiturates, sedatives, or sleeping pills | ❑ | ❑ | ❑ |
| Sulfa drugs | ❑ | ❑ | ❑ |
| Codeine or other narcotics | ❑ | ❑ | ❑ |
| Latex | ❑ | ❑ | ❑ |
| Iodine | ❑ | ❑ | ❑ |
| Hay fever/seasonal | ❑ | ❑ | ❑ |
| Animals | ❑ | ❑ | ❑ |
| Food (specify) _____ | ❑ | ❑ | ❑ |
| Other (specify) _____ | ❑ | ❑ | ❑ |
| Metals (specify) _____ | ❑ | ❑ | ❑ |

**To yes responses, specify type of reaction.**

| | Yes | No | Don't Know |
|---|---|---|---|
| Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? | ❑ | ❑ | ❑ |

If yes, when was this operation done?

If you answered yes to the above question, have you had any complications or difficulties with your prosthetic joint?

| | Yes | No | Don't Know |
|---|---|---|---|
| Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? | ❑ | ❑ | ❑ |

If yes, what antibiotic and dose?

Name of physician or dentist*:

Phone:

## WOMEN ONLY

| | Yes | No | Don't Know |
|---|---|---|---|
| Are you or could you be pregnant? | ❑ | ❑ | ❑ |
| Nursing? | ❑ | ❑ | ❑ |
| Taking birth control pills or hormonal replacement? | ❑ | ❑ | ❑ |

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

| | Yes | No | Don't Know |
|---|---|---|---|
| Abnormal bleeding | ❑ | ❑ | ❑ |
| AIDS or HIV infection | ❑ | ❑ | ❑ |
| Anemia | ❑ | ❑ | ❑ |
| Arthritis | ❑ | ❑ | ❑ |
| Rheumatoid arthritis | ❑ | ❑ | ❑ |
| Asthma | ❑ | ❑ | ❑ |
| Blood transfusion. If yes, date: _____ | ❑ | ❑ | ❑ |
| Cancer/Chemotherapy/Radiation Treatment | ❑ | ❑ | ❑ |
| Cardiovascular disease. If yes, specify below: | ❑ | ❑ | ❑ |

____ Angina
____ Arteriosclerosis
____ Artificial heart valves
____ Congenital heart defects
____ Congestive heart failure
____ Coronary artery disease
____ Damaged heart valves
____ Heart attack
____Heart murmur
____High blood pressure
____Low blood pressure
____Mitral valve prolapse
____Pacemaker
____Rheumatic heart disease/Rheumatic fever

| | | | |
|---|---|---|---|
| Chest pain upon exertion | ❑ | ❑ | ❑ |
| Chronic pain | ❑ | ❑ | ❑ |
| Disease, drug, or radiation-induced immunosurpression | ❑ | ❑ | ❑ |
| Diabetes. If yes, specify below: | ❑ | ❑ | ❑ |

____ Type I (Insulin dependent) ____Type II

| | | | |
|---|---|---|---|
| Dry Mouth | ❑ | ❑ | ❑ |
| Eating disorder. If yes, specify: _____ | ❑ | ❑ | ❑ |
| Epilepsy | ❑ | ❑ | ❑ |
| Fainting spells or seizures | ❑ | ❑ | ❑ |
| Gastrointestinal disease | ❑ | ❑ | ❑ |
| G.E. Reflux/persistent heartburn | ❑ | ❑ | ❑ |
| Glaucoma | ❑ | ❑ | ❑ |

| | Yes | No | Don't Know |
|---|---|---|---|
| Hemophilia | ❑ | ❑ | ❑ |
| Hepatitis, jaundice or liver disease | ❑ | ❑ | ❑ |
| Recurrent Infections | ❑ | ❑ | ❑ |

If yes, indicate type of infection: _____

| | | | |
|---|---|---|---|
| Kidney problems | ❑ | ❑ | ❑ |
| Mental health disorders. If yes, specify: _____ | ❑ | ❑ | ❑ |
| Malnutrition | ❑ | ❑ | ❑ |
| Night sweats | ❑ | ❑ | ❑ |
| Neurological disorders. If yes, specify: _____ | ❑ | ❑ | ❑ |
| Osteoporosis | ❑ | ❑ | ❑ |
| Persistent swollen glands in neck | | | |
| Respiratory problems. If yes, specify below: | ❑ | ❑ | ❑ |

____ Emphysema ____ Bronchitis, etc.

| | | | |
|---|---|---|---|
| Severe headaches/migraines | ❑ | ❑ | ❑ |
| Severe or rapid weight loss | ❑ | ❑ | ❑ |
| Sexually transmitted disease | ❑ | ❑ | ❑ |
| Sinus trouble | ❑ | ❑ | ❑ |
| Sleep disorder | ❑ | ❑ | ❑ |
| Sores or ulcers in the mouth | ❑ | ❑ | ❑ |
| Stroke | ❑ | ❑ | ❑ |
| Systemic lupus erythematosus | ❑ | ❑ | ❑ |
| Tuberculosis | ❑ | ❑ | ❑ |
| Thyroid problems | ❑ | ❑ | ❑ |
| Ulcers | ❑ | ❑ | ❑ |
| Excessive urination | ❑ | ❑ | ❑ |

| | Yes | No | Don't Know |
|---|---|---|---|
| Do you have any disease, condition, or problem not listed above that you think I 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. 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 they take or do not take because of errors or omissions that I may have made in the completion of this form.

SIGNATURE OF PATIENT/LEGAL GUARDIAN DATE

## FOR COMPLETION BY DENTIST

Comments on patient interview concerning health history:

Significant findings from questionnaire or oral interview:

Dental management considerations:

**Health History Update:** On a regular basis the patient should be questioned about any medical history changes, date and comments notated, along with signature.

| Date | Comments | Signature of patient and dentist |
|---|---|---|
| | | |
| | | |