

## HEALTH HISTORY

Name \_\_\_\_\_ HomePhone \_\_\_\_\_ WorkPhone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Social Security # \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender: M F  
Email address \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Work Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company Name \_\_\_\_\_ Group#/Policy# \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Company Phone \_\_\_\_\_  
Name of Insured \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_  
If you are completing this form for another person, what is your relationship to that person? \_\_\_\_\_

*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. We do not use this information to discriminate. Please note that during your visits you may be asked questions concerning your health. This information is vital to allow us to provide appropriate care for you.*

### Dental Information

#### Yes No Don't Know

- Do your gums bleed when you brush?  
   Are your teeth sensitive to cold, hot, sweets or pressure?  
   Have you had any periodontal (gum) treatment?  
   Have you had any serious/difficult problem associated with any previous dental treatment? If so, please explain \_\_\_\_\_

#### Yes No Don't Know

- Have you had orthodontic treatment?  
   Do you have headaches, earache or neck pain?  
   Do you wear removable dental appliances?

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How would you describe your current dental situation? \_\_\_\_\_  
Date of your last dental exam \_\_\_\_\_  
What was done at that time? \_\_\_\_\_  
How do you feel about the appearance of your teeth? \_\_\_\_\_

### Medical Information

#### Yes No Don't Know

- Are you in good health?  
   Has there been any change in your general health in the past year?

**If your answer is 'yes' to any of the 3 questions below, please stop and return this form to the receptionist.**

- Do you have active tuberculosis?  
   Have you had a persistent cough for more than 3 weeks?  
   Do you have a cough that produces blood?

Physician Name \_\_\_\_\_  
Physician Address \_\_\_\_\_  
Physician Phone \_\_\_\_\_ Date of last Physical Examination \_\_\_\_\_

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May we contact your physician? ( ) Yes ( ) No

#### Yes No Don't Know

- Are you currently being treated for any medical conditions? If so, what condition(s)? \_\_\_\_\_  
   Have you had a serious illness, operation or hospitalization in the past 5 years? If so, what was the illness or problem? \_\_\_\_\_  
   Are you taking or have you recently taken any medicines, including non prescription medicine? If so, what medicines are you taking? \_\_\_\_\_

**Yes No Don't Know**

- Do you drink alcoholic beverages? If yes, how many drinks per day? \_\_\_\_\_ per week? \_\_\_\_\_
- Do you use drugs or other substances for recreational purposes? If yes, what substances? \_\_\_\_\_
- Frequency of use? \_\_\_\_\_
- Have you ever received treatment for alcohol or drug dependency?
- Do you use tobacco (smoking, snuff, chew)? If yes, are you interested in stopping? \_\_\_\_\_
- Do you wear contact lenses?

**Allergies: Are you allergic to or have you had a reaction to:**

**Yes No Don't Know**

- Local Anesthetic
- Aspirin
- Penicillin or other antibiotics
- Barbiturates, sedatives or sleeping pills

**Yes No Don't Know**

- Codeine or other narcotics
- Sulfa drugs
- Latex
- Other (please specify)

**Please indicate if you have or have had any of the following:**

**Yes No Don't know**

- Abnormal bleeding
- AIDS or HIV
- Anemia
- Arthritis or Rheumatoid Arthritis
- Asthma
- Blood transfusion
- Cancer treatment
- Cardiovascular disease
- If yes, specify below:
- Angina
- Arteriosclerosis
- Artificial heart valves
- Coronary insufficiency
- Coronary occlusion
- Damaged heart valves
- Heart attack
- Heart murmur
- High blood pressure
- Inborn heart defects
- Mitral valve prolapse
- Pacemaker
- Rheumatic heart disease
- Chest pain upon exertion
- Chronic pain
- Persistent diarrhea

**Yes No Don't Know**

- Immunosuppression
- Diabetes
- Dry mouth
- Eating disorder
- Epilepsy
- Fainting spells or seizures
- G.E. Reflux
- Glaucoma
- Hemophilia
- Hepatitis, jaundice or liver disease
- Recurrent infections
- Kidney problems
- Low blood pressure
- Mental health disorders
- Malnutrition
- Migraines
- Night sweats
- Neurological disorder
- If yes, please specify \_\_\_\_\_
- Osteoporosis
- Persistent swollen glands in neck
- Respiratory problems
- If yes, please specify \_\_\_\_\_
- Severe or rapid weight loss
- Sexually transmitted disease

**Yes No Don't Know**

- Sinus trouble
- Sleep disorder
- Sores or ulcers in the mouth
- Stroke
- Systemic lupus erythematosus
- Thyroid problems
- Tuberculosis
- Ulcers
- Excessive urination
- Other, if yes, please specify

**Women only**

- Are you pregnant?
- Are you nursing?
- Are you taking birth control pills?

**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 because of errors or omissions that I may have made in the completion of this form.

\_\_\_\_\_  
Signature of patient or legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Doctor

\_\_\_\_\_  
Date

