Health History Form

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive, or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that 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. Medications and health conditions can sometimes affect your oral health and it is important for accurate diagnosis to have accurate information.

***We are a latex free office and will notify you if metal is necessary for any restorations

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Age:_____

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

Dental Information *Please mark yes or no*

Do your gums bleed when you brush or floss?..... ___Yes ___ No Date of last dental exam_____
Are your teeth sensitive to cold, hot, or pressure? …….. ___Yes ___ No
Do you have dry mouth?..... ___Yes ___ No If dental treatment is needed would you like
Have you had any periodontal (gum) treatments?..... ___Yes ___ No to have"laughing gas".....___Yes___No
Have you ever had any problems associated with dental treatment?... ___Yes ___ No There is a $50 charge for every 30 minutes
Are you currently experiencing dental pain or discomfort?.....___Yes ___ No
How do you feel about your smile?_____

Medical Information *Please mark yes or no*

Are you under the care of a physician? ____ Yes ___ No Name of Physician:_____Phone:_____
Have you had any serious illness, operation, or been hospitalized in the past 5 years? ___ Yes ___ No
If yes, what was the illness or problem?_____
Are you currently taking any prescription or over the counter medications? ___Yes ___ No
If yes, please list all, including vitamins, natural/herbal/diet supplements. (If you have a list we can make a copy for you)

Drug/Dosage	Prescribing Physician	Taken For

Joint Replacement Have you had an orthopedic joint (hip, knee, elbow) replacement? ___Yes ___ No Date_____
Has a physician recommended that you take antibiotics prior to your dental treatment? ___Yes ___ No

Please mark yes or no to indicate if you have had or have not had any of the following diseases or problems.

Heart murmur…….___Yes ___ No
Mitral valve prolapse……..___Yes ___ No
Artificial heart valves……..___Yes ___ No
Rheumatic Fever……...___Yes ___ No
Cardiovascular Disease….___Yes ___ No
Angina (chest pain).....___Yes ___ No
Congestive heart failure....___Yes ___ No
Heart attack…….___Yes ___ No
Low/High blood pressure...___Yes ___ No
Congenital heart defects…___Yes ___ No
Pacemaker……..___Yes ___ No
Abnormal bleeding…….___Yes ___ No
Neurological disorders…...___Yes ___ No
Anemia……..___Yes ___ No
Hemophilia……...___Yes ___ No
AIDS or HIV infection…..___Yes ___ No
Arthritis……..___Yes ___ No
Autoimmune disease…...___Yes ___ No
Emphysema……..___Yes ___ No
Tuberculosis……..___Yes ___ No
Cancer……...___Yes ___ No
Chronic pain…….___Yes ___ No
Diabetes……___Yes ___ No
Gastrointestinal Disease...___Yes ___ No
Reflux/Heartburn……...___Yes ___ No
Mental health Disorders...___Yes ___ No
Thyroid problems...___Yes ___ No
Stroke……..___Yes ___ No
Hepatitis……..___Yes ___ No
Liver disease……...___Yes ___ No
Epilepsy……...___Yes ___ No
Fainting…….. ___Yes ___ No
Kidney problems... ___Yes ___ No
Osteoporosis…….. ___Yes___No
Migraines……. ___Yes___No
STD……. ___Yes___No
Asthma……...___Yes___No

Please explain any disorders or diseases along with any condition or problem not listed above:_____
_____

Allergies: are you allergic to or have you have a reaction to: *Please mark yes or no*

To all **YES** responses, specify type of reaction.

Local anesthetics……..___Yes___No
Aspirin……___Yes___No
Penicillin or other antibiotics……___Yes___No
Barbiturates, sedatives, or sleeping pills….___Yes___No
Sulfa drugs……___Yes___No
Codeine or other narcotics……..___Yes___No
Metals……___Yes___No
Latex (rubber).....___Yes___No
Iodine……___Yes___No
Hay fever/Seasonal…….___Yes___No
Food……..___Yes___No
Other……___Yes___No
Reactions:_____

Women only Are you: *please mark yes or no*

Pregnant: ___Yes___No Number of weeks:_____ Nursing: ___Yes___No Taking birth control/hormones: ___Yes___No

Signature of Patient/Legal Guardian:_____