

HEALTH HISTORY FORM

Patient's Name _____

Date of Birth ____/____/____

Gender _____ Height _____ Weight _____

Today's Date _____

**An accurate and complete health history will assist in coordinating your dental care.
Please speak with the doctor or staff if there are any questions about this form.**

DENTAL HISTORY

Please describe your current dental health: Excellent Good Fair Poor

Please describe why you are in the office today _____

Have there been any changes in your dental health in the past year? Yes / No

If yes, please describe _____

Are you having any dental discomfort at this time? Yes / No

If yes, please describe _____

Have you had any adverse effects from dental treatment? Yes / No

If yes, please describe _____

Date of last dental visit? _____

DENTAL HISTORY - Do you have or have you ever had any of the following:

| | | | |
|---------------------------------|----------|------------------------------------|----------|
| Bleeding, sore gums? | Yes / No | Shifting in bite? | Yes / No |
| Unpleasant taste/bad breath? | Yes / No | Change in bite? | Yes / No |
| Swelling/lumps in mouth? | Yes / No | Burning tongue/lips? | Yes / No |
| Orthodontic treatment (braces?) | Yes / No | Frequent blister, lips/mouth? | Yes / No |
| Clenching/grinding? | Yes / No | Sensitive teeth (hot or cold?) | Yes / No |
| Sensitive to sweets? | Yes / No | Clicking/popping jaw? | Yes / No |
| Sensitive to biting? | Yes / No | Difficulty opening or closing jaw? | Yes / No |
| Food Impaction? | Yes / No | Loose teeth? | Yes / No |
| Biting cheeks/lips? | Yes / No | | |

MEDICAL HISTORY

Please describe your current overall health: Excellent Good Fair Poor

Have there been any changes in your general health in the past year? Yes / No

If yes, please describe: _____

Are you now under a doctor's care for a medical condition? Yes / No

Date of last physical exam? _____

If yes, please describe _____

Name of physician _____ Physician phone number _____

Have you ever been hospitalized or had a serious illness? Yes / No

If yes, please describe _____

Have you ever had surgery? Yes / No

If yes, please describe _____

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MEDICAL HISTORY (continued) - Do you have, or have you ever had, any of the following conditions:

| | | | |
|---|----------|--|----------|
| Congenital heart disease, cardiovascular disease – like heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker? | Yes / No | Lung disease – like asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing? | Yes / No |
| Implants placed anywhere in the body – like heart valve, pacemaker, hip, knee? | Yes / No | Bleeding disorder, anemia, bleeding tendency, blood transfusion, or bruise easily? | Yes / No |
| Kidney disease or kidney failure, requiring dialysis? | Yes / No | Liver disease – like jaundice, hepatitis A, B, or C? | Yes / No |
| Thyroid disease? | Yes / No | Arthritis? | Yes / No |
| Stomach ulcers or colitis? | Yes / No | Significant weight loss or gain? | Yes / No |
| Diabetes? | Yes / No | Sinus or nasal problems? | Yes / No |
| Glaucoma? | Yes / No | Sleep apnea? | Yes / No |
| Cancer? | Yes / No | Osteoporosis or osteopenia? | Yes / No |

If yes, type _____

Diagnosis date _____

Treatments _____

Do you have any other medical conditions that are important for your doctor to know about? Yes / No

If yes, please describe _____

FAMILY MEDICAL HISTORY - Do you have a family history of any of the following conditions?

| | | | | | |
|---------------|----------|--------------------|--------------------|----------|--------------------|
| Diabetes? | Yes / No | Relationship _____ | Heart disease? | Yes / No | Relationship _____ |
| Lung disease? | Yes / No | Relationship _____ | Bleeding problems? | Yes / No | Relationship _____ |
| Cancer? | Yes / No | Relationship _____ | | | |

Has an immediate family member had any problems with local anesthesia, general anesthesia, and/or intravenous sedation? Yes / No

If yes, please describe _____

MEDICATIONS – Are you currently prescribed or taking any of the following:

| | | | |
|--|----------|--|----------|
| Antibiotics? | Yes / No | Prescription pain medication? | Yes / No |
| Anticoagulants or blood thinners? | Yes / No | Aspirin or drugs such as Motrin, Aleve, Ibuprofen? | Yes / No |
| Heart medications? | Yes / No | Insulin or oral anti-diabetic drugs? | Yes / No |
| Steroids – like cortisone or prednisone? | Yes / No | Blood pressure medications? | Yes / No |
| Antianxiety agents, antidepressants, or other psychiatric medications? | Yes / No | Bisphosphonates or other medications to strengthen your bones? | Yes / No |
| Cancer or chemotherapy drugs? | Yes / No | Any other medications or supplements? | Yes / No |

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MEDICATIONS (continued): Please list the specific medications indicated above and/or any other medications not listed above that you are currently taking. Please including all prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins, or minerals:

| Medication and dose | Medication and dose |
|---------------------|---------------------|
| | |
| | |
| | |

ALLERGIES – Are you allergic to or have you had an adverse reaction to:

| | | | |
|----------------------------|----------|---|----------|
| Latex? | Yes / No | Codeine or other pain control medications? | Yes / No |
| Food or food products? | Yes / No | Aspirin, ibuprofen (Motrin), or naproxen (Aleve)? | Yes / No |
| Sedatives or barbiturates? | Yes / No | Penicillin or other antibiotics? | Yes / No |
| Any other medications? | Yes / No | Any other allergies? | Yes / No |

If yes, please describe _____

Pharmacy:

ANESTHESIA HISTORY

Have you had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes / No

If yes, please describe _____

FEMALE PATIENTS Are you pregnant? Yes / No Is there any chance you might be pregnant? Yes / No

SOCIAL HISTORY

| | |
|---|---|
| <p>Have you ever smoked, vaped or chewed tobacco? Yes / No If yes, for how long? _____</p> <p>Have you ever sought professional care or been hospitalized for:</p> <p>Substance abuse Yes / No</p> <p>Emotional disorders Yes / No</p> <p>Alcoholism Yes / No</p> | <p>Do you use:</p> <p>Alcohol? Yes / No If yes, how often per week? _____</p> <p>Marijuana? Yes / No If yes, how often per week? _____</p> <p>Recreational drugs? Yes / No If yes, how often per week? _____</p> |
|---|---|

I understand the importance of a truthful and complete health history to assist my doctor in providing coordinated care. To the best of my knowledge, the above information is complete and correct.

Signature of patient, parent, guardian

Date

Printed name of patient, parent, guardian/Relationship

