HEALTH HISTORY FORM

Name _____ Weight _____ Height _____ BMI _____

Birthdate _____

DENTAL INFORMATION

	Yes	No
Do your gums bleed when you brush or floss?	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐
Does food or floss catch in-between your teeth?	☐	☐
Have you ever had periodontal (gum) therapy?	☐	☐
Have you had dental surgery?	☐	☐
Do you wear partials or dentures?	☐	☐
Is your mouth dry?	☐	☐
Do you use hard candy/throat lozenges daily?	☐	☐
Are you on a special diet?	☐	☐
Do you drink energy drinks, soda, sweetened tea/coffee?	☐	☐
Is bottled/filtered or well water your main source of water?	☐	☐
Have you ever had braces?	☐	☐
Do you have earaches or neck pain?	☐	☐

	Yes	No
Do you have clicking, popping or discomfort in the jaw?	☐	☐
Do you grind your teeth?	☐	☐
Have you had cold sores in the mouth or on the lips?	☐	☐
Do you participate in active sports/recreational activities?	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐
Are you currently experiencing dental discomfort/pain?	☐	☐
Have you ever had a negative dental experience?	☐	☐

If yes, please explain _____

_____

What is the reason for your visit today? _____

Date of last dental exam_____date of last x-rays _____

Previous Dentist name_____

MEDICAL INFORMATION

	Yes	No
Are you currently under the care of a physician/specialist?	☐	☐

If yes, what condition is being treated? _____

List medications/supplements and reason for taking: _____

_____

_____

_____

_____

Physician Name _____

Date of last physical exam _____

Physician Phone _____ Fax _____

Pharmacy Phone_____

	Yes	No
Have you had a serious illness, operation or hospitalization in your lifetime?	☐	☐

If yes, reason _____

_____

_____

Do you have dental phobia or anxiety?	☐	☐
Do you have gag reflex?	☐	☐
Do you or your family members have a history of anesthesia problems?	☐	☐

Explain_____

_____

_____

The answers to the following questions are relevent due to any medication or sedation we may prescribe for you.

	Yes	No
Do you wear contact lenses?	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐

Date:_____If yes, have you had any complications?_____

Are you taking or have you ever taken medications for osteoporosis, bone disease, bone cancer including Bisphosphanates?	☐	☐

Date Treatment began_____

Do you use recreational drugs?	☐	☐

If yes, specify:

_____

_____

_____

	Yes	No
Do you currently use, or have you ever used tobacco products (smoking, snuff, chew, vaping)?	☐	☐
If so, how interested are you in stopping?	☐	☐

(Circle one) VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages?	☐	☐

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

If yes, how much do you typically drink in a week?_____

WOMEN ONLY Are you:

Pregnant?	☐	☐

Number of weeks_____

Taking birth control pills or hormone replacement?	☐	☐
Nursing?	☐	☐

	Yes	No
Allergies. Are you allergic to or have you had a reaction to:		
To all **yes** responses, specify type of reaction.		
Local anesthetics _____	☐	☐
Aspirin _____	☐	☐
Penicillin or other antibiotics _____	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐
Sulfa drugs _____	☐	☐
Codeine or other narcotics _____	☐	☐
Adhesive Tapes _____	☐	☐
Metals _____	☐	☐
Latex (Rubber) _____	☐	☐
Iodine _____	☐	☐
Hay fever/seasonal _____	☐	☐
Animals _____	☐	☐
Food _____	☐	☐
Other _____	☐	☐

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

	Yes	No
Artificial (Prosthetic) heart valve	☐	☐
Previous infective endocarditis	☐	☐
Damaged valves in transplanted heart	☐	☐
Congenital heart disease (CHD)		
Unrepaired, cyanotic CHD	☐	☐
Repaired (completely) in last 6 months	☐	☐
Repaired CHD with residual defects	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No
Cardiovascular disease	☐	☐
Angina	☐	☐
Arteriosclerosis	☐	☐
Congestive heart failure	☐	☐
Damaged heart valves	☐	☐
Heart attack	☐	☐
Heart murmur	☐	☐
Low blood pressure	☐	☐
High blood pressure	☐	☐
Other congenital heart defects	☐	☐
Mitral valve prolapse	☐	☐
Pacemaker	☐	☐
Rheumatic fever	☐	☐
Rheumatic heart disease	☐	☐
Abnormal bleeding	☐	☐
Anemia	☐	☐
Blood transfusion	☐	☐
If yes, date: _____		
Hemophilia	☐	☐
AIDS or HIV infection	☐	☐
Arthritis	☐	☐
Autoimmune disease	☐	☐
Rheumatoid arthritis	☐	☐
Systemic lupus erythematosus	☐	☐
Asthma	☐	☐
If yes, specify: _____		

	Yes	No
Bronchitis	☐	☐
Emphysema	☐	☐
Sinus trouble	☐	☐
Tuberculosis	☐	☐
Cancer/Chemotherapy/ Radiation treatment	☐	☐
Chest pain upon exertion	☐	☐
Chronic pain	☐	☐
Diabetes Type I or II	☐	☐
Eating disorder	☐	☐
Malnutrition	☐	☐
Gastrointestinal disease	☐	☐
G.E. Reflux/persistent heartburn	☐	☐
Ulcers (stomach)	☐	☐
Thyroid problems	☐	☐
Stroke	☐	☐
Glaucoma	☐	☐
Hepatitis, jaundice or liver disease	☐	☐
Epilepsy	☐	☐
Fainting spells or seizures	☐	☐
Sleep disorder/ sleep apnea	☐	☐
If yes, please specify: _____		

	Yes	No
Mental health disorders	☐	☐
Specify: _____		
Neurological or Genetic disorders	☐	☐
If yes, specify: _____		
Recurrent infections	☐	☐
Type of infection: _____		
Kidney problems	☐	☐
Excessive urination	☐	☐
Night sweats	☐	☐
Osteoporosis	☐	☐
Persistent swollen glands in neck	☐	☐
Severe headaches/ migraines	☐	☐
Severe or rapid weight loss	☐	☐
Sexually transmitted disease	☐	☐
If yes, please specify type: _____		

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐
Name of physician or dentist making recommendation: _____ Phone _____		
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 information given on this form is accurate. I understand the importance of a truthful health history and my dentist and his/her staff will rely on this informaiton for 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 member of his/her staff, responsible for any action taken or not taken because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

Print Name: _____ Date: _____