HEALTH HISTORY FORM

Email address: ______________________ Today's date ______________

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. This office does not use this information to discriminate.

Patient Name: ______________________________

Home Phone ______________________ Business Cell Phone ______________

Mailing Address ______________ City __________ State __________ Zip ________

Occupation ______________ Height ______________ State ______________

Date of Birth ______________________ Sex M F

SS # or Patient ID ______________________ Relationship ______________

Home Phone ______________________ Cell Phone ______________

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

Your Name ______________________ Relationship ______________

Do you have any of the following diseases or problems: (Check DK if you Don't Know the answer to the question)

Active Tuberculosis Yes No DK

Persistent cough greater than a 3 week duration. Yes No DK

Cough that produces blood Yes No DK

Been exposed to anyone with tuberculosis Yes No DK

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

DENTAL INFORMATION

Do your gums bleed when you brush or floss? Yes No DK

Are your teeth sensitive to cold, hot, sweets or pressure? Yes No DK

Is your mouth dry? Yes No DK

Have you had any periodontal (gum) treatments? Yes No DK

Have you ever had orthodontic (braces) treatment? Yes No DK

Have you had any problems associated with previous dental treatment? Yes No DK

Is your home water supply fluoridated? Yes No DK

Do you drink bottled or filtered water? Yes No DK

If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY Yes No DK

Are you currently experiencing dental pain or discomfort? Yes No DK

Do you have earaches or neck pains? Yes No DK

Do you have any clicking, popping or discomfort in the jaw? Yes No DK

Do you brux or grind your teeth? Yes No DK

Do you have sores or ulcers in your mouth? Yes No DK

Do you wear dentures or partials? Yes No DK

Do you participate in active recreational activities? Yes No DK

Have you ever had a serious injury to your head or mouth? Yes No DK

Date of your last dental exam: ______________ What was done at that time? ______________

Date of last dental x-rays ______________

What is the reason for your dental visit today? ______________

How do you feel about your smile? ______________

MEDICAL INFORMATION

Are you now under the care of a physician? Yes No DK

Physician Name ______________ Phone ______________

Address ______________________ City ______________ State __________ Zip _________

Are you in good health? Yes No DK

Has there been any change in your general health within the past year? Yes No DK

If yes, what condition is being treated? ____

Date of last physical exam ____

Are you taking or have you recently taken any prescription or over the counter medicine(s)?

Yes No DK

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements

____

Do you wear contact lenses? Yes No DK

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

Yes No DK

If yes, have you had any complications? ____

____

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? Yes No DK

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Yes No DK

____

Do you use controlled substances (drugs)? Yes No DK

Do you use tobacco (smoking, snuff, chew, bidis)? Yes No DK

If so, how interested are you in stopping? Yes No DK

Do you drink alcoholic beverages? Yes No DK

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? Yes No DK

If yes, how much do you typically drink i n a week? ______________________________

Taking birth control pills or hormonal replacement? Yes No DK

Nursing? Yes No DK

Allergies. Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction.

Local anesthetics Yes No DK

Aspirin Yes No DK

Penicillin or other antibiotics Yes No DK

Barbiturates, sedatives, or sleeping pills Yes No DK

Sulfa drugs Yes No DK

Codeine or other narcotics Yes No DK

Metals Yes No DK

Latex (rubber) Yes No DK

Iodine Yes No DK

Hay fever/seasonal Yes No DK

Animals Yes No DK

Food Yes No DK

Other Yes No DK

Artificial (prosthetic) heart valve Yes No DK

Previous infective endocarditis Yes No DK

Damaged valves in transplanted heart Yes No DK

Congenital heart disease (CHD) Unrepaired, cyanotic CHD Yes No DK

Repaired (completely) in last 6 months Yes No DK

Repaired CHD with residual defects Yes No DK

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

Cardiovascular disease Yes No DK

Mitral valve prolapse Yes No DK

Angina Yes No DK

Pacemaker Yes No DK

Arteriosclerosis Yes No DK

Rheumatic fever Yes No DK

Congestive heart failure Yes No DK

Rheumatic heart disease Yes No DK

Damaged heart valves Yes No DK

Abnormal bleeding Yes No DK

Heart attack Yes No DK

Heart murmur Yes No DK

Blood transfusion Yes No DK

if yes, date ______________________

Low blood pressure Yes No DK

Hemophilia Yes No DK

Other congenital heart defects Yes No DK

AIDS or HIV infection Yes No DK

Arthritis Yes No DK

Autoimmune disease Yes No DK

Glaucoma Yes No DK

Rheumatoid arthritis Yes No DK

Hepatitis, jaundice or liver disease Yes No DK

Systemic lupus erythematosus Yes No DK

Epilepsy Yes No DK

Asthma Yes No DK

Fainting spells or seizures Yes No DK

Bronchitis Yes No DK

Neurological disorders Yes No DK

If yes, specify ______________________

Emphysema Yes No DK

Sleep disorder Yes No DK

Tuberculosis Yes No DK

Do you snore? Yes No DK

Cancer/Chemotherapy/ Radiation Treatment Yes No DK

Mental health disorders Yes No DK

Specify ______________________

Recurrent Infections Yes No DK

Type of infection ______________________

Chest pain upon exertion Yes No DK

Kidney problems Yes No DK

Chronic pain Yes No DK

Night sweats Yes No DK

Eating disorder Yes No DK

Osteoporosis Yes No DK

Malnutrition Yes No DK

Persistent swollen glands in neck Yes No DK

G.E. Reflux/persistent heartburn Yes No DK

Severe headaches/ migraines Yes No DK

Ulcers Yes No DK

Severe or rapid weight loss Yes No DK

Thyroid problems Yes No DK

Sexually transmitted disease Yes No DK

Stroke Yes No DK

Excessive urination Yes No DK

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

Yes No DK

Name of physician or dentist making recommendation ______________________

Phone: Include area code ______________________

Do you have any disease, condition, or problem not listed above that you think I should know about?

Yes No DK

Please explain ______________________