PATIENT HEALTH HISTORY FORM

Patient's Name: | **Today's Date:**

Address:

City, State, Zip: | **Email:**

Home Phone: | **Work Phone:** | **Cell Phone:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

General Dentist Name: | **General Dentist Phone:**

Physician Name: | **Physician Phone:**

Pharmacy: | **Pharmacy Phone:**

Sex:

Height:

Weight:

If female, please answer the following:

Y N

☐ ☐ Are you pregnant? If Yes, how many weeks? _____

☐ ☐ Are you nursing

☐ ☐ Are you taking Birth Control Pills?

Please answer the following:

Y N

☐ ☐ Have you been out of the country in the past 21 days?

☐ ☐ Have you had a fever, headache, or diarrhea in the past 10 days?

Please answer the following:

Y N

☐ ☐ Do you currently use tobacco? If Yes, how long? _____

☐ ☐ Have you used tobacco in the past?
If Yes, for how long and when did you quit? _____

☐ ☐ Do you use any controlled substances (drugs)?

☐ ☐ Do you drink alcoholic beverages?
If Yes, how many drinks per week? _____

Do you have any of the following diseases or problems?

Y N

☐ ☐ Active tuberculosis

☐ ☐ Persistent cough greater than a 3 week duration

☐ ☐ Cough that produces blood

☐ ☐ Been exposed to anyone with tuberculosis

Please answer the following:

Y N

☐ ☐ Have you had a serious illness, operation or been hospitalized in the past 5 years? If Yes, please explain: _____

☐ ☐ Do you currently have cancer, or have you had cancer in the past? If Yes, please explain: _____
Will you, or have you had chemotherapy or radiation therapy? _____

☐ ☐ Have you had an orthopedic total joint (hip, knee, elbow) replacement? If Yes, please describe: _____

☐ ☐ Are you currently taking, or have you ever taken oral bisphosphonates for treatment of osteoporosis?

☐ ☐ Are you currently taking, or have you ever taken IV bisphosphonates? If Yes, please describe: _____

Y N	**Conditions**
☐ ☐	Abnormal Bleeding
☐ ☐	Anemia
☐ ☐	Angina Pectoris
☐ ☐	Arthritis
☐ ☐	Asthma
☐ ☐	Autoimmune Disease
☐ ☐	Blood Transfusion
☐ ☐	Cancer: Chemotherapy, Radiation Therapy
☐ ☐	Cardiovascular Disease
☐ ☐	Cold Sores (Fever Blisters)
☐ ☐	Colitis
☐ ☐	Congenital Heart Defect
☐ ☐	Cosmetic Surgery
☐ ☐	Diabetes

Y N	**Conditions**
☐ ☐	Difficulty Breathing
☐ ☐	Emphysema
☐ ☐	Epilepsy / Seizures
☐ ☐	Fainting Spells
☐ ☐	Gastric Reflux (GERD, Heartburn)
☐ ☐	Glaucoma / Cataracts
☐ ☐	HIV / AIDS
☐ ☐	Hay Fever
☐ ☐	Heart Attack
☐ ☐	Heart Murmur
☐ ☐	Heart Surgery
☐ ☐	Hemophilia
☐ ☐	Hepatitis A, B or C
☐ ☐	High Blood Pressure
☐ ☐	Kidney Problems

Y N	**Conditions**
☐ ☐	Liver Disease
☐ ☐	Low blood Pressure
☐ ☐	Mitral Valve Prolapse
☐ ☐	Osteoporosis
☐ ☐	Pacemaker
☐ ☐	Psychiatric Problems
☐ ☐	Rheumatoid Arthritis
☐ ☐	Shingles
☐ ☐	Sickle Cell Disease
☐ ☐	Sinus Problems
☐ ☐	Sleep Apnea
☐ ☐	Stroke
☐ ☐	Thyroid Problems
☐ ☐	Ulcers
☐ ☐	Venereal Disease

Y N	**Allergies**
☐ ☐	Aspirin
☐ ☐	Codeine
☐ ☐	Dental Anesthetics
☐ ☐	Dental Acrylics
☐ ☐	Erythromycin
☐ ☐	Latex
☐ ☐	Metals
☐ ☐	Penicillin
☐ ☐	Sulfa Medications
☐ ☐	Tetracycline

Other: _____
_____
_____

Current Medications

Past Surgical History

Dental Information

Y	N		Y	N	
☐	☐	Do your gums bleed when you brush or floss?	☐	☐	Do you have earaches or neck pains?
☐	☐	Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	Do you have any clicking, popping or discomfort in the jaws?
☐	☐	Does food or floss catch between your teeth?	☐	☐	Do you brux or grind your teeth?
☐	☐	Do you suffer from chronic dry mouth?	☐	☐	Do you have sores or ulcers in your mouth?
☐	☐	Have you had any periodontal (gum) treatments?	☐	☐	Do you wear dentures or partials?
☐	☐	Have you ever had orthodontic (braces) treatment?	☐	☐	Have you ever had a serious injury to your head or mouth?
☐	☐	Have you ever had dental implant treatment?	☐	☐	Are you currently experiencing dental pain or discomfort?
☐	☐	Have you had any problems associated with previous dental treatment? If Yes, please describe: _____	When was the last time you saw your dentist? What was done at that visit? _____		

What is the reason for your dental visit today?

How do you feel about your smile?

Please answer the following:

Y N

☐ ☐ Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe: _____
_____
_____

Notes

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 and that the information given is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information 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 they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient (If under 18, parent or guardian signature required):	**Date:**