HEALTH HISTORY [redacted]

Name _____ Birth date _____

As required by law, our office adheres to written policies and procedures to protect the privacy of information that you provide to us. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you may be asked additional questions about your responses to this questionnaire. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Dental Information

	Yes	No	DK
Are you having any discomfort at this time?	□	□	□
Have you ever had any serious trouble associated with previous dental treatment?	□	□	□
If so, explain? _____			
Does dental treatment make you nervous? □ No □ Slightly □ Moderately □ Extremely			
Date of your last dental visit:			
What was done at the time?			
Date of last full mouth x-rays:			
Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)?	□	□	□

Do you have or have you ever had any of the following? (Check DK if you Don't Know the answer to the question)

	Yes	No	DK		Yes	No	DK
Bleeding, sore gums	□	□	□	Loose teeth	□	□	□
Unpleasant taste/bad breath	□	□	□	Sensitive to hot	□	□	□
Burning tongue/lips	□	□	□	Sensitive to cold	□	□	□
Frequent blisters, lip/mouth	□	□	□	Sensitive to sweets	□	□	□
Swelling/lumps in mouth	□	□	□	Sensitive to biting	□	□	□
Ortho treatment (braces)	□	□	□	Food impaction	□	□	□
Biting cheeks/lips	□	□	□	Clenching/grinding	□	□	□
Clicking, popping, or discomfort in the jaw	□	□	□	If so, when _____			
Difficulty opening or closing jaw	□	□	□	Change in bite	□	□	□
Dry mouth	□	□	□				
Wear dentures or partials	□	□	□				

How often do you use the following?

Toothbrush _____ Fluoride rinse _____

Dental floss _____ Other _____

Mouthwash _____

Medical Information

	Yes	No	DK
Are you now under the care of a physician?	□	□	□
Physician's Name: Phone: ( )			
Address/City/State/Zip:			
Has there been any change in your general health within the past year?	□	□	□
If yes, what condition is being treated?			
Date of last physical exam:			
Have you had a serious illness, operation or been hospitalized in the past 5 years?	□	□	□
If yes, what was the illness or problem			

Current Medications

Are you taking any of the following:

	Yes	No	DK		Yes	No	DK
Antibiotics or sulfa drugs	□	□	□	Antihistamines	□	□	□
Anticoagulants (blood thinners)	□	□	□	Aspirin	□	□	□
Medicine for high blood pressure	□	□	□	Insulin, tolbutamide (Orinase) or similar drug for diabetes	□	□	□
Cortisone (steroids)	□	□	□	Digitalis or drugs for heart trouble	□	□	□
Tranquilizers	□	□	□	Nitroglycerin	□	□	□

Please list all current medications below:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

	Yes	No	DK
Joint replacement. Have you had an orthopedic total joint (hip, knee, etc.) replacement? ..... Date: _____ If yes, have you had any complications? _____	□	□	□
Experiencing increased stress or pressure at home or work? ..	□	□	□
Do you wear contact lenses?	□	□	□
Are you now, or have you ever taken any bisphosphonates for osteoporosis (like Fosamax©, Actonel©, Atelvia, Boniva©, Reclast, Prolia) or IV formulations (Aredia or Zometa) for chemotherapy?	□	□	□
WOMEN ONLY Are you:			
Pregnant? ..... Number of Weeks: _____	□	□	□

	Yes	No	DK
Do you use tobacco (smoking, snuff, chew, bidis). ..... 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? _____	□	□	□
Do you use controlled substances (drugs)?	□	□	□
Taking birth control pills or hormonal replacement?	□	□	□
Nursing?	□	□	□

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

	Yes	No	DK
Local anesthetics _____	□	□	□
Penicillin or other antibiotics _____	□	□	□
Aspirin _____	□	□	□
Sulfa drugs _____	□	□	□
Barbiturates, sedatives, or sleeping pills _____	□	□	□
Codeine or other narcotics _____	□	□	□
Metals _____	□	□	□
Latex (rubber) _____	□	□	□
Iodine _____	□	□	□
Hay fever/seasonal _____	□	□	□
Animals _____	□	□	□
Food _____	□	□	□
Other _____	□	□	□

Do you have any of the following diseases or problems?

	Yes	No	DK
Prior history of tuberculosis or active tuberculosis	□	□	□
Persistent cough greater than a 3 week duration	□	□	□
Cough that produces blood	□	□	□
Been exposed to anyone with tuberculosis	□	□	□

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

	Yes	No	DK
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	□	□	□
Autoimmune disease	□	□	□
Rheumatoid arthritis	□	□	□
Systematic lupus erythematosus	□	□	□
Asthma	□	□	□
Bronchitis	□	□	□
Emphysema	□	□	□
Sinus trouble	□	□	□
Cancer/Chemotherapy/ Radiation Treatment	□	□	□
Surgery for tumor/ growth or other condition	□	□	□
Chronic pain	□	□	□
Diabetes Type I or II	□	□	□
Eating disorder	□	□	□
Malnutrition	□	□	□
Gastrointestinal disease	□	□	□
G.E. Reflux/persistent heartburn	□	□	□
ADD/ADHD	□	□	□
Ulcers	□	□	□
Thyroid problems	□	□	□
Stroke	□	□	□
Glaucoma	□	□	□
Hepatitis, jaundice, or liver disease	□	□	□
Epilepsy	□	□	□
Fainting spells or seizures	□	□	□
Neurological disorders.. If yes, specify: _____	□	□	□
Sleep disorder	□	□	□
Do you snore?	□	□	□
Mental health disorders. Specify: _____	□	□	□
Recurrent Infections	□	□	□
Type of infection: _____			
Kidney problems	□	□	□
Night sweats	□	□	□
Osteoporosis	□	□	□
Persistent swollen glands in neck	□	□	□
Severe headaches/migraines	□	□	□
Severe or rapid weight loss	□	□	□
Sexually transmitted disease	□	□	□
Excessive urination	□	□	□

	Yes	No	DK
Cardiovascular disease	□	□	□
Angina	□	□	□
Arteriosclerosis	□	□	□
Congestive heart failure	□	□	□
Damaged heart valves	□	□	□
Heart attack	□	□	□
Heart murmur	□	□	□
Mitral valve prolapse	□	□	□
Low blood pressure	□	□	□
High blood pressure	□	□	□
Other congenital heart defects	□	□	□
Chest pain upon exertion	□	□	□
Shortness of breath	□	□	□
Ankles swell	□	□	□
Pacemaker	□	□	□
Rheumatic fever	□	□	□
Rheumatic heart disease	□	□	□
Abnormal bleeding	□	□	□
Anemia	□	□	□
Blood transfusion If yes, date: _____	□	□	□
Hemophilia	□	□	□
AIDS or HIV infection	□	□	□
Arthritis	□	□	□

	Yes	No	DK
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 treatments.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his 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 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 Date