DENTAL HEALTH HISTORY FORM

Today's Date:

Our office follows written policies and procedures to protect the privacy of your personal information. 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. We do not use this information to discriminate.

Patient Name:		Health Record #:	

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

Your Name: Your Relationship:

Do you have any of the following?	Yes	No	Unsure
Active Tuberculosis			
Persistent cough greater than 3 week duration			
Cough that produces blood			
Have you been exposed to anyone with tuberculosis			

If you answered yes to any of the questions above please stop and return this form to the front desk

Dental Information

Date of your last dental exam:		Date of last dental x-rays:	

Has a physician or dentist recommended that you take antibiotics prior to your dental treatment? YES ☐ NO ☐

If yes, name and phone number of provider:

Medical Information	Yes	No	If yes, please explain
Has your general health changed within the past year?			
Have you had a serious illness, operation or been hospitalized in the past 5 years?			
Are you under the care of a physician?			
Are you pregnant?			# of weeks:
Are you nursing?			
Do you smoke or use tobacco?			Type and how often?
Are you interested in quitting tobacco?			
Do you drink alcoholic beverages?			How often?
Do you use controlled substances (drugs)?			

Your Primary Care Provider's (PCP) Name:

PCP Phone Number:		Date of your last physical exam:	

Your Medications	Yes	No
Are you taking birth control pills or hormonal replacement?		
Are you taking blood thinning medicines such as Aspirin, Heparin, Coumadin or Naproxen?		
Are you taking or are you scheduled to begin taking alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease?		
Were you treated or are you presently scheduled to begin treatment with intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastic cancer?		
Are you taking or have you recently taken any prescription or over the counter medicines?		

Please list all your medications, including vitamins, natural or herbal preparations and/or diet supplements:

Are you allergic to any of the following?	Yes	No	Type of Reaction
Local Anesthetics or Epinephrine			
Aspirin, Ibuprofen or NSAIDs			
Penicillin or other antibiotics			
Barbiturates, sedatives or sleeping pills			
Sulfa drugs			
Codeine or other narcotics			
Metals			
Latex (rubber)			

Allergies, continued…	Yes	No	Type of Reaction
Iodine			
Hay fever/seasonal			
Animals			
Food			
Other			

Have you had any of the following?	Yes	No		Yes	No
Orthopedic total joint replacement?			Emphysema		
Have you had any complications?			Sinus trouble		
Artificial (prosthetic) heart valve			Tuberculosis		
Previous infective endocarditis			Cancer		
Damaged valves in heart transplant			*Chemotherapy Treatment*		
Congenital heart disease (CHD)			*Radiation Treatment*		
Unrepaired, cyanotic			Chest pain upon exertion		
Repaired in last 6 months			Chronic pain		
Repaired with residual defects			Diabetes type I or II		
Cardiovascular Disease			Eating disorder		
Angina			Malnutrition		
Arteriosclerosis			Gastrointestinal disease		
Congestive heart failure			G.E. reflux/persistent heartburn		
Damaged heart valves			Ulcers		
Heart attack			Thyroid Problems		
Heart murmur			Stroke		
Low blood pressure			Glaucoma		
High blood pressure			Hepatitis, jaundice, liver disease		
Other congenital heart defects			Epilepsy		
Mitral valve prolapse			Fainting spells or seizures		
Pacemaker			Neurological disorders		
Rheumatic fever			*Type:*		
Rheumatic heart disease			Sleep disorders		
Abnormal bleeding			Mental health disorders		
Anemia			*Specify:*		
Blood transfusion (if yes, date:)			Recurrent infections		
Hemophilia			*Type:*		
AIDS or HIV Infection			Kidney problems		
Arthritis			Osteoporosis		
Autoimmune disease			Persistent swollen neck glands		
Rheumatoid arthritis			Severe headaches/migraines		
Systemic lupus erythematosus			Severe or rapid weight loss		
Asthma			Sexually transmitted disease		
Bronchitis					

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

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 on this form is accurate. I understand the importance of a truthful health history and that my dentist and their 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 their staff, responsible for any action they take or do not take because of errors or omissions on this form.

Signature of Patient or Legal Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____