PATIENT NAME _____ REG# _____

Date of birth _____

HEALTH HISTORY FORM

*Please **MARK** the appropriate response next to each question below: Yes (Y), No (N), Don't Know (?)*

MEDICAL HISTORY

Do you have or have you had any of the following:

	Y	N	?
1. Breathing problems?			
a. Asthma	☐	☐	☐
b. Emphysema	☐	☐	☐
c. Bronchitis	☐	☐	☐
d. Tuberculosis	☐	☐	☐
e. Shortness of breath	☐	☐	☐
f. Other breathing problems	☐	☐	☐

Explain: _____

	Y	N	?
2. Heart or circulation problems?			
a. High blood pressure	☐	☐	☐
b. Heart attack	☐	☐	☐
c. Angina or chest pain	☐	☐	☐
d. Irregular heart beat	☐	☐	☐
e. Rheumatic fever	☐	☐	☐
f. Heart murmur	☐	☐	☐
g. Mitral valve prolapse	☐	☐	☐
h. Damage to heart valves	☐	☐	☐
i. Heart valve replacement	☐	☐	☐
j. Pacemaker/other cardiac device	☐	☐	☐
k. Congestive heart failure	☐	☐	☐
l. Swollen ankles	☐	☐	☐
m. Other heart or circulation problems	☐	☐	☐

Explain: _____

	Y	N	?
3. Kidney or urinary problems?			
a. Kidney disease	☐	☐	☐
b. Dialysis	☐	☐	☐
c. Frequent urination	☐	☐	☐
d. Other kidney problems	☐	☐	☐

Explain: _____

	Y	N	?
4. Nervous system problems?			
a. Stroke or transitory ischemic attack	☐	☐	☐
b. Fainting spells	☐	☐	☐
c. Convulsions, seizures or epilepsy	☐	☐	☐
d. Other nervous system problems	☐	☐	☐

Explain: _____

	Y	N	?
5. Head and neck problems?			
a. Nose or sinus problems	☐	☐	☐
b. Swollen glands	☐	☐	☐
c. Oral cancer	☐	☐	☐
d. Impairment of hearing, sight or speech	☐	☐	☐
e. Frequent or severe headaches	☐	☐	☐
f. Other head and neck problems	☐	☐	☐

Explain: _____

	Y	N	?
6. Hormone or gland problems?			
a. Thyroid disease (hypothyroidism, hyperthyroidism)	☐	☐	☐
b. Diabetes	☐	☐	☐
c. Adrenal or pancreatic disease	☐	☐	☐
d. Any other hormone/gland disease	☐	☐	☐

Explain: _____

	Y	N	?
7. Muscle, bone or skin problems?			
a. Arthritis	☐	☐	☐
b. Osteoporosis	☐	☐	☐
c. Artificial joint placement	☐	☐	☐
d. Hives or skin rash	☐	☐	☐
e. Skin cancer	☐	☐	☐
f. Back problems	☐	☐	☐
g. Other muscle, bone or skin disease	☐	☐	☐

Explain: _____

	Y	N	?
8. Stomach, liver, intestinal problems?			
a. Liver disease	☐	☐	☐
b. Hepatitis	☐	☐	☐
c. Acid reflux (GERD)	☐	☐	☐
d. Ulcers	☐	☐	☐
e. Other stomach, intestinal or liver problems	☐	☐	☐

Explain: _____

EXAMINER'S COMMENTS _____

_____

_____

_____

over please

9. Allergic reactions or other problems? Y N ?

a. Seasonal allergies ☐ ☐ ☐

b. Allergy, reaction or intolerance to:

Penicillin ☐ ☐ ☐
Erythromycin ☐ ☐ ☐
Codeine ☐ ☐ ☐
Latex ☐ ☐ ☐
Local anesthetics ☐ ☐ ☐
Foods/flavoring ☐ ☐ ☐
Other substances ☐ ☐ ☐

Explain: _____

_____

10. Blood or immune system problems? Y N ?

a. Cancer of any type ☐ ☐ ☐
b. Organ or bone marrow transplant ☐ ☐ ☐
c. Lupus ☐ ☐ ☐
d. Multiple sclerosis ☐ ☐ ☐
e. Anemia ☐ ☐ ☐
f. Hemophilia ☐ ☐ ☐
g. AIDS/HIV ☐ ☐ ☐
h. Frequent nosebleeds, increased bruising or bleeding ☐ ☐ ☐
i. Are you taking any blood thinners? ☐ ☐ ☐
j. Have you had chemotherapy or radiation treatment? ☐ ☐ ☐
k. Other problems with the blood or immune system? ☐ ☐ ☐

Explain: _____

11. ***What medications or other substances are you taking or have you taken in the past 2 months?***

a. Please list all prescription and non-prescription drugs including aspirin, birth control pills, herbal medications or other supplements. Write "none" if you are not taking any medications or other substances.

_____

_____

_____

_____ Y N ?

b. Have you ever taken the drugs Fenfluramine(Fen-phen), Pondimin, or Dexfenfluramine(Redux)? ☐ ☐ ☐

c. Have you taken or are you taking drugs to control bone loss? (ie. Fosamax®) ☐ ☐ ☐

12. Personal History

a. Have you ever been hospitalized, had major surgery or been seriously hurt? ☐ ☐ ☐

If yes, what type and when_____

b. Have you had or do you have any sexually transmitted diseases (syphilis, gonorrhea, herpes, etc.)? ☐ ☐ ☐
c. Do you need any special accommodations for dental treatment? ☐ ☐ ☐
d. Are you pregnant? ☐ ☐ ☐
e. Have you ever used tobacco products? ☐ ☐ ☐
f. Are you currently using tobacco products? ☐ ☐ ☐

What type and how often _____

g. How many alcohol containing drinks do you consume a week? _____
h. Do you use or have you used recreational drugs? ☐ ☐ ☐
i. Have you ever had a problem with alcohol and/or drugs? ☐ ☐ ☐
j. Do you have mental health problems? ☐ ☐ ☐
k. When was your last visit to a physician (medical doctor)? _____
l. Do you have a physician (medical doctor)? ☐ ☐ ☐

If yes, please provide the Name, Address and Telephone _____

_____

EXAMINER'S COMMENTS _____

_____

_____

_____

DENTAL HISTORY

1. What is the reason for your dental visit? _____

_____

	Y	N	?
2. Have you ever had any problems following dental treatment?	☐	☐	☐
If yes, please explain _____			
3. Have you ever had a bad or unusual reaction to local anesthetic?	☐	☐	☐
4. Have you ever had a severe injury to your face, teeth or jaws?	☐	☐	☐
5. Have you ever had surgery in your mouth or on your lips?	☐	☐	☐
6. Have you ever had periodontal treatment to your gums?	☐	☐	☐
7. Have you ever had orthodontic treatment to straighten your teeth?	☐	☐	☐
8. Have you ever had extraction (pulling) of any teeth?	☐	☐	☐
9. Have you ever had endodontics (root canals) on any teeth?	☐	☐	☐
10. Have you had any missing teeth replaced by a removable denture, fixed bridge or an implant?	☐	☐	☐
11. Have you ever worn a bitesplint/nightguard?	☐	☐	☐
12. Have you had a recent toothache?	☐	☐	☐
13. Are your teeth sensitive to hot, cold or pressure?	☐	☐	☐
14. Do you have bleeding gums?	☐	☐	☐
15. Do you have trouble chewing?	☐	☐	☐
16. Do you clench or grind your teeth?	☐	☐	☐
17. Do you have difficulty opening your mouth as wide as you would like?	☐	☐	☐
18. Do your jaw joints or muscles hurt?	☐	☐	☐
19. Does your jaw click, pop or lock when you chew?	☐	☐	☐
20. Do you experience a dry mouth?	☐	☐	☐
21. Do you have sores in or around your mouth?	☐	☐	☐
22. Please mark the amount of sugar in your diet.	small ☐	moderate ☐	high ☐

23. When was the last time your teeth were cleaned at a dental office? _____
24. How often do you brush? _____
25. How often do you use dental floss? _____
26. Are you satisfied with the appearance of your teeth? ☐ ☐ ☐
    If No, Why not? _____
27. Do you have any questions, concerns, or additional information you would like us to know before we treat you? ☐ ☐ ☐
    If Yes, please specify? _____

    _____
28. How do you feel about going to the dentist? Scared ☐ Apprehensive ☐ No problem ☐

EXAMINER'S COMMENTS _____

_____

_____

_____

over please