Health History Form

ADA American Dental Association®

America's leading advocate for oral health

| E-mail: | Today's Date: |
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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

| Been exposed to anyone with tuberculosis. If you answer yes to any of the 4 items above, please stop and return this form to the receptionist. Dental Information For the following questions, please mark (X) your responses to the following questions. Yes No DK Do you gums bleed when you brush or floss? Do you have earaches or neck pains? Do you have earaches or neck pains? Do you have any clicking, popping or discomfort in the jaw? Do you brus or grind your teeth? Do you brus or grind your teeth? Do you have sores or ulcers in your mouth? Have you had any periodontal (gum) treatments? Do you wear dentures or partials? Do you wear dentures or partials? Do you principate in active recreational activities? Do you of the following disease or problems. Pres No DK What is the reason for your dental visit today? Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems. Yes No DK Yes No DK Yes No DK Have you now under the care of a physician? Phone: Include area code () If yes, what was the illness or problem? | Name: | | | | | Home Phone: | Include area cod | le Business/Cell Ph | one: Include | area code | | 1. |
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| Height: Weight: Date of birth: Sex M F | | | | | | City: | | State: | | Zip: | | |
| f you are completing this form for another person, what is your relationship to that person? Now Name Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Relationship: Re | Mailing address | | | | | | | | | | | |
| if you are completing this form for another person, what is your relationship to that person? Relationship Oo you have any of the following diseases or problems: (Check DK if you Don't Know the answer to the question) Oo you have any of the following diseases or problems: (Check DK if you Don't Know the answer to the question) Cough that produces blood. Cough that produces blood. Cough that produces blood. If you answer yes to any of the 4 items above, please stop and return this form to the receptionist. Oo your gums bleed when you brush or floss? Yes No DK Yes No DK Yes No DX Yes No DX Oo you gums bleed when you brush or floss? Yes No DX Yes You'responses to the following questions. Yes No DX Yes | Occupation: | | | | | Height: | Weight: | Date of birth: | | Sex: N | Λ | F |
| If you are completing this form for another person, what is your relationship to that person? Relationship Dob you have any of the following diseases or problems: (Check DK If you Don't Know the answer to the question) Ves No Check DK If you Don't Know the answer to the question Check DK If you Don't Know the answer to the question Check DK If you Don't Know the answer to the question Check DK If you Don't Know the answer to the question Check DK If you Don't Know the answer to the question Check DK If you Don't Know the answer to the question Check DK If you Don't Know the answer to the question Check DK If you Don't Know the answer to the question Check DK If you Don't Know the answer to the question Check DK If you Don't Know the answer to the question Check DK If you Don't Know the answer to the question Check DK If you Don't Know the answer to the question Check DK If you Don't Developed Check DK If you | SS# or Patient ID: | Emergency Contact: | | | | Relationship: | | Home Phone: | Cell P | none: | | |
| Now have any of the following diseases or problems: (Check DK if you Don't Know the answer to the question) Persistent cough greater than a 3 week duration. Cough that produces blood Been exposed to anyone with fuberculosis. If you answer yes to any of the 4 items above, please stop and return this form to the receptionist. Dental Information For the following questions, please mark (X) your responses to the following questions. Yes No DK Do you have earaches or neck pains? Oever teeth sensitive to cold, hot, sweets or pressure? Do you have any clicking, popping or discomfort in the jaw? Sey our mouth dir? Do you have sores or ulcers in your mouth? Do you have sores or ulcers in your mouth? Do you have any clicking, popping or discomfort in the jaw? Do you have sores or ulcers in your mouth? Do you have sores or ulcers in your mouth? Do you have pour teeth? Do you had any periodontal (gum) treatments? Do you had any problems associated with previous dental reatment? Do you had any problems associated with previous dental reatment? Do you have or partials? Have you ever had a serious injury to your head or mouth? Date of your fast 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 Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems. Yes No DK Yes No DK If yes, who often? Circle one: DAILY / WEEKLY / OCCASIONALLY Are you unow under the care of a physician? Phone: Include area code () If yes, what was the illness, operation or been hospitalized in the past 5 years? Description or over the counter medicine(s)? Are you taking or have you recently taken any prescription or over the counter medicine(s)? If yes, what was the illness or problem? Are you taking or have you recently taken any prescription or over the counter medicine(s)? If yes, what was the illness or problem? Are you taking or have you r | | | | | | | | () Include area of | codes |) | | |
| Do you have any of the following diseases or problems: Check DK if you Don't Know the answer to the question | f you are completing this form f | or another person, what is yo | ur relations | hip t | to t | hat person? | | | | | | |
| Active Tuberculosis. | Your Name | | | | | Relationship | | | | | | |
| Persistent cough greater than a 3 week duration. | | | | | | | | | | | | |
| Cough that produces blood. | | | | | | | | | | | | |
| Been exposed to anyone with tuberculosis. If you answer yes to any of the 4 items above, please stop and return this form to the receptionist. Dental Information For the following questions, please mark (X) your responses to the following questions. Ves No DK Do your gums bleed when you brush or floss? Are your teeth sensitive to cold, hot, sweets or pressure? Do you have earaches or neck pains? Do you have any clicking, popping or discomfort in the jaw? Do you have sores or ulcres in your mouth? Do you have sores or ulcres in your mouth? Do you have sores or ulcres in your mouth? Do you have your dear destrues or partials? Do you participate in active recreational activities? Have you had any problems associated with previous dental treatment? Do you drink bottled or filtered water? By sour home water supply fluoridated? Do you drink bottled or filtered water? By syour home water supply fluoridated? Do you drink bottled or filtered water? By so office one: DAILY / WEEKLY / OCCASIONALLY Are you currently experiencing dental pain or discomfort? What is the reason for your dental visit today? What is the reason for your dental visit today? What is the reason for your dental visit today? Wes No DK Are you now under the care of a physician? Phone: Include area code () If yes, what was the illness or problem? Are you taking or have you recently taken any prescription or over the counter medicine(s)? Are you flag then the past of your general health within he past year? Including vitamins, natural or herbal preparations and/or diet supplements: And or over the counter medicine(s)? If yes, please list all, including vitamins, natural or herbal preparations and/or diet supplements: | | | | | | | | | | | | |
| Dental Information For the following questions, please mark (X) your responses to the following questions. Ves No DK Do you have earaches or neck pains? Do you have sore or neck pains? Do you part neck pains? Do you have sore or neck pains? Do you have recreational activities? Do you have you read entures or partials? Do you have you had a serious injury to your head or mouth? Do you have you have you have not have not had any of the following diseases or problems. Do you have you had a serious illness, operation or been hospitalized in the past 5 years? Do you have you recently taken any prescription Do you have you now under the care of a physician? Do you have you recently taken any prescription Do you have you in good health? Do you have you recently taken any prescription Do you have you had a serious il | | | | | | | | | | | | |
| Deental Information For the following questions, please mark (X) your responses to the following questions. Yes No DK Do you have possible Do you have earaches or neck pains? Do you have any clicking, popping or discomfort in the jaw? Do you have sores or ulcers in your mouth? Do you have any clicking, popping or discomfort in the jaw? Do you was dentures or partials? Do you have any clicking, popping or discomfort in the jaw? Do you was dentures or partials? Do you mean dentures or partials? Do you have any clicking popping or discomfort in the jaw? Do you have any clicking, popping or discomfort in the jaw? Do you was dentures or partials? Do you mean dentures or partials? Do you mean dentures or partials? Do you have any clicking, popping or discomfort in the jaw? Do you was dentures or partials? Do you was dentures or partials? Do you was dentures or partials? Do you wear dentures or partials? Do you wear dentures or partials? Do you was dentures or partials? Do you was dentures or partials? Do you was dentures or partials? Do you denture the gover had a serious injury to your head or mouth? Date of your last dental exam: What was done at that time? Date of your last dental exam: What was done at that time? Date of last dental x-rays: | | | | | | | | | | ⊔ | | |
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| Ves No DK O your gums bleed when you brush or floss? Or your gums bleed when you brush or floss? Or your gums bleed when you brush or floss? Or you gums bleed when you brush or floss? Or you gums bleed when you brush or floss? Or you was dearaches or neck pains? Or you have earaches or neck pains? Or you have any clicking, popping or discomfort in the jaw? Or you was dearaches or neck pains? Or you was or your deeth? Or you have sores or ulcers in your mouth? Or you have sores or ulcers in your mouth? Or you was dentures or partials? Have you wear dentures or partials? Or you was dentures or partials? Have you ever had a serious injury to your head or mouth? Or you drink bottled or filtered water? Or you have or have not had any of the following diseases or problems. Yes No DK Have you had a serious illness, operation or been hospitalized in the past 5 years? Or you filt year. Are you taking or have you recently taken any prescription or over th | ental Informat | ion for the following gues | tions plans | | nels | M was raspar | asas ta tha fe | allowing guestians | | | | |
| Do you have earaches or neck pains? | rental informat | TOTT FOR the following ques | | | | (A) your respon | ises to the it | ollowing questions. | | Voc | No | |
| Are your teeth sensitive to cold, hot, sweets or pressure? | On your gums bleed when you h | orush or floss? | | | | Do you have | earaches or i | nock nains? | | | | |
| Do you brux or grind your teeth? | | | | | | | | | | | | |
| Adve you wear had orthodontic (braces) treatments? | | | | | | | | | | | | |
| Have you had any periodontal (gum) treatments? | | | | | | | | | | | | |
| Have you ever had orthodontic (braces) treatment? | | | | | | | | | | | | |
| Have you had any problems associated with previous dental reatment? | | | | | | | | | | | | |
| Date of your last dental exam: What was done at that time? Date of your last dental exam: What was done at that time? Date of last dental exam: What was done at that time? Date of last dental exam: What was done at that time? Date of last dental x-rays: Date of last d | | | 🗀 🗀 | | | | | | | | | |
| So your home water supply fluoridated? | | | | , , | _ | Have you eve | r nad a serio | ous injury to your nead or i | moutn? | Ц | | |
| Do you drink bottled or filtered water? | | | | | | Date of your | last dental ex | xam: | | | | |
| Are you now under the care of a physician? Physician Name: Phone: Include area code () Phone: Include area code () Are you in good health? Are you in good health? Are you in good health? Are you general health within he past year? Are you currently experiencing dental pain or discomfort? Date of last dental x-rays: Phone: Include area code of a physician of the following diseases or problems. Yes No Date of last dental x-rays: Phone: Include area code of a physici | | | | | | What was do | ne at that tir | me? | | | | |
| Are you response to indicate if you have or have not had any of the following diseases or problems. Yes No DK Have you now under the care of a physician? Physician Name: Phone: Include area code () If yes, what was the illness or problem? Are you taking or have you recently taken any prescription or over the counter medicine(s)? Are you in good health? Are you in good health? If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: | | | | J L | _ | | | | | | | |
| What is the reason for your dental visit today? How do you feel about your smile? Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems. Yes No DK Yes No DK Have you now under the care of a physician? Physician Name: Phone: Include area code () If yes, what was the illness or problem? Are you in good health? Are you in good health? Are you in good health? Are you faking or have you recently taken any prescription or over the counter medicine(s)? If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: | | | | | | Date of last d | ental x-rays: | | | | | |
| How do you feel about your smile? Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems. Yes No DK Have you had a serious illness, operation or been hospitalized in the past 5 years? | | | | | | | | | | | | |
| Are you now under the care of a physician? Physician Name: Phone: Include area code () Address/City/State/Zip: Are you in good health? Are you in good health? Are you good health within he past year? Are you good health within he past year? Are you good health within he past year? Are you fact a fix you have or have not had any of the following diseases or problems. Yes No D Ave you had a serious illness, operation or been hospitalized in the past 5 years? If yes, what was the illness or problem? Are you taking or have you recently taken any prescription or over the counter medicine(s)? If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: | What is the reason for your dent | al visit today? | | | | | | | | | | |
| Are you now under the care of a physician? Phone: Include area code () | How do you feel about your smi | le? | | | | | | | | | | |
| Are you now under the care of a physician? Phone: Include area code () | | | | | Decree of the last | | | | | | | |
| Are you now under the care of a physician? Phone: Include area code () | 4 L L C | - A - C - C - C - C - C - C - C - C - C | | | | | | | | | | |
| Are you now under the care of a physician? Phone: Include area code () | viedical informa | ITION Please mark (X) you | r response | to in | ndica | ate if you have | or have not | had any of the following | diseases or | oroblen | ns. | |
| Physician Name: Phone: Include area code () If yes, what was the illness or problem? Address/City/State/Zip: Are you in good health? Are you in good health? Are you family | | | Yes N | o D | K | | | | | | | DI |
| Address/City/State/Zip: Are you taking or have you recently taken any prescription or over the counter medicine(s)? Has there been any change in your general health within he past year? If yes, what was the illness or problem? Are you taking or have you recently taken any prescription or over the counter medicine(s)? If yes, what was the illness or problem? | | physician? | | | | | | | | | | |
| Are you taking or have you recently taken any prescription Are you in good health? or over the counter medicine(s)? | Physician Name: | Phone: | Include area co | de | | hospitalized in | n the past 5 | years? | | | | |
| Are you taking or have you recently taken any prescription or over the counter medicine(s)? | | () | | | | If yes, what w | vas the illness | s or problem? | | | | ā- |
| Are you in good health? | Address/City/State/Zip: | | | | | | | | | | | |
| Are you in good health? | | | | | | Are you taking | g or have yo | u recently taken any presc | ription | | | |
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| Date of last physical exam: | | | | | | | | | | | | |

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems. (Check DK if you Don't Know the answer to the question) Yes No DK Yes No DK Do you wear contact lenses? Do you use controlled substances (drugs)?..... Joint Replacement. Have you had an orthopedic total joint (hip, Do you use tobacco (smoking, snuff, chew, bidis)?..... knee, elbow, finger) replacement? If so, how interested are you in stopping? Date: _____ If yes, have you had any complications? (Circle one) VERY / SOMEWHAT / NOT INTERESTED Are you taking or scheduled to begin taking either of the Do you drink alcoholic beverages?..... medications, alendronate (Fosamax®) or risedronate (Actonel®) If ves, how much alcohol did you drink in the last 24 hours? for osteoporosis or Paget's disease? If yes, how much do you typically drink In a week? _____ Since 2001, were you treated or are you presently scheduled WOMEN ONLY Are you: to begin treatment with the intravenous bisphosphonates Pregnant? (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal Number of weeks: complications resulting from Paget's disease, multiple myeloma Taking birth control pills or hormonal replacement?..... or metastatic cancer? Nursing? Date Treatment began: Allergies - Are you allergic to or have you had a reaction to: Yes No DK Yes No DK To all **yes** responses, specify type of reaction. Local anesthetics_____ Latex (rubber) lodine ___ Hay fever/seasonal Penicillin or other antibiotics Barbiturates, sedatives, or sleeping pills _____ Animals_____ Sulfa drugs Food Codeine or other narcotics Other ___ Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems. Yes No DK Yes No DK Yes No DK Autoimmune disease Hepatitis, jaundice or Artificial (prosthetic) heart valve Previous infective endocarditis Rheumatoid arthritis liver disease Damaged valves in transplanted heart..... Systemic lupus erythematosus. Epilepsy Congenital heart disease (CHD) Unrepaired, cyanotic CHD..... Asthma..... Fainting spells or seizures...... Neurological disorders..... Bronchitis..... Repaired (completely) in last 6 months Emphysema Repaired CHD with residual defects Sinus trouble..... Tuberculosis Mental health disorders Except for the conditions listed above, antibiotic prophylaxis is no longer recommended Cancer/Chemotherapy/ Specify: for any other form of CHD. Radiation Treatment Recurrent Infections...... Yes No DK Yes No DK Chest pain upon exertion Type of infection: Kidney problems..... Angina Pacemaker 🗆 🗆 Diabetes Type I or II........ Night sweats..... Osteoporosis...... Eating disorder..... Congestive heart failure Rheumatic heart disease...... Malnutrition..... Persistent swollen glands Damaged heart valves...... Abnormal bleeding Gastrointestinal disease...... in neck Heart attack Anemia...... G.E. Reflux/persistent Severe headaches/ Heart murmur Blood transfusion heartburn Ulcers Low blood pressure..... If yes, date:_____ Severe or rapid weight loss High blood pressure...... Thyroid problems Sexually transmitted disease Excessive urination..... Other congenital heart AIDS or HIV infection Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Phone: Name of physician or dentist making recommendation: 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 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 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. Date: Signature of Patient/Legal Guardian: FOR COMPLETION BY DENTIST Comments: