## ADA American Dental Association® America's leading advocate for oral health

## Health History Form

E-mail:	Today's Date:

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

this questionnaire and there may be additional questic does not use this information to discriminate.	ons concerning y	our h	ealth.	This information	on is vital to allo	vill be asked some questions ow us to provide appropriate	about your care for you	respo u. Thi	nses to s office
Name:				Home Phone:	Include area code	Business/Cell Phone	: Include area c	ode	
Last First	Mid	ldle		'( )		( )			
Address:				City:		State:	Zip:		
Mailing address									
Occupation:				Height:	Weight:	Date of birth:	Sex:	М	F
SS# or Patient ID: Emergency C	ontact:			Relationship:		Home Phone:	Cell Phone:		
If you are completing this form for another person, v	what is your relat	ionshi	in to 1	that nerson?		Include area codes			
2 X AW	mat is your relat	.10115111	ip to						
Your Name  Do you have any of the following diseases or pi	roblems:			Relationship	DV:( D V				
Active Tuberculosis				(Cneck	DK IT YOU DON'T	Know the answer to the que	estion) Yes	No	DK
Persistent cough greater than a 3 week duration							Ц		
Cough that produces blood									
Been exposed to anyone with tuberculosis									П
If you answer yes to any of the 4 items above, p								ш	
					TAX TONOUS				
Dental Information For the follow				(X) your respon	nses to the follo	owing questions.	Selection.	arole of	
	Yes	No	DK				Yes	No	DK
Do your gums bleed when you brush or floss?						ck pains?			
Are your teeth sensitive to cold, hot, sweets or pressu						opping or discomfort in the j			
Does food or floss catch between your teeth?						eeth?			
Is your mouth dry?						in your mouth?			
Have you had any periodontal (gum) treatments?						rtials?			
Have you ever had orthodontic (braces) treatment?						recreational activities?			
Have you had any problems associated with previous de		_		Have you eve	r had a serious	injury to your head or mout	th? 🗆		
treatment?				Date of your	last dental exar	n:			
Is your home water supply fluoridated?				What was do	ne at that time	?			
Do you drink bottled or filtered water?									
If yes, how often? Circle one: DAILY / WEEKLY / OCCA		_	_	Date of last d	lental x-rays:				
Are you currently experiencing dental pain or discomi	fort? 📙	Ш							
What is the reason for your dental visit today?									
How do you feel about your smile?									
Medical Information Please mark	k (X) your respor	nse to	indica	ate if you have	or have not ha	d any of the following disea	ses or proble	ems.	
Are you now under the care of a physician?	Yes	No	DK				Yes	No	DK
	Phone: Include an					ss, operation or been	-		
rnysician Name.	( )	ea code	•		n the past 5 yea vas the illness o	ars?r problem?	Ц		
Address/City/State/Zip:				yes, mac n	vas trie illitess o	prodictit.			
,				A					
Are you in good health?						ecently taken any prescription (e(s)?		П	
Has there been any change in your general health withir	1	_	_			vitamins, natural or herbal			_
the past year?	□			and/or diet su		,			
If yes, what condition is being treated?									
Date of last physical exam:									_

Medical Information Please mark (X) you	r response to	o ind	icate	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)  Do you wear contact lenses?	Yes			Yes  Do you use controlled substances (drugs)? □		DK		
Are you taking, or have you taken, any diet drugs such as Pondimin (fenflluramine), Redux (dexphenfluramine) or phen-fen (fenflluramine-phentermine combination)?				Do you use tobacco (smoking, snuff, chew, bidis)?				
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel® for osteoporosis or Paget's disease?				Do you drink alcoholic beverages?				
Since 2001, were you treated or are you presently schedule				WOMEN ONLY Are you:				
to begin treatment with the intravenous bisphosphonates				Pregnant?				
(Aredia® or Zometa®) for bone pain, hypercalcemia or skelet				Number of weeks:				
complications resulting from Paget's disease, multiple myeld or metastatic cancer?		П		Taking birth control pills or hormonal replacement?				
Date Treatment began:		J	_	Nulsing:				
	nt (hin knee	elh	ow f	inger) replacement?	П	П		
Date: If yes, have you had an	y complicati	ions?	Ovv, 1	riger/ replacement:				
Allerce es - Are you allergic to or have you had a reaction t				Yes	No	DK		
To all jes responses, specify type of reaction.				Metals				
Local anesthetics				Latex (rubber)				
AspirinPenicillin or other antibiotics				Iodine  Hay fever/seasonal				
Barbiturates, sedatives, or sleeping pills				Animals				
Sulfa drugs				Food				
Sulfa drugsCodeine or other narcotics				Other				
Please mark (X) your response to indicate if you have or ha	ve not had a	any c	of the	following diseases or problems.				
Yes No DK		No			No			
Heart murmur				Chronic pain				
Wilder varve prolapse				Diabetes Type I or II		-		
Artificial heart valves				Malnutrition				
AIDS or HIV infection				Gastrointestinal disease    Type of infection:				
Cardiovascular disease 🗆 🖂 Arthritis				G.E. Reflux/persistent Kidney problems				
Angina				heartburn          Night sweats           Ulcers          Steoporosis				
Arteriosclerosis	5 □			Thyroid problems				
Coronary artery disease				Stroke				
Damaged heart valves   Asthma				Glaucoma				
Heart attack 🗆 🗆 Bronchitis				Hepatitis, jaundice or migraines				
Low blood pressure				liver disease				
High blood pressure				Fainting spells or seizures Excessive urination				
Pacemaker				Neurological disorders				
Rheumatic heart disease 🗆 🖂 🖂 Radiation Treatme				If yes, Specify:				
Abnormal bleeding 🗆 🗆 Chest pain upon ex								
Has a physician or previous dentist recommended that you	take antibio	otics	prior	to your dental treatment? $\square$				
Name of physician or dentist making recommendation:				Phone:				
Do you have any disease, condition, or problem not listed a Please explain:	above that y	ou tl	nink I	should know about?				
history and that my dentist and his/her staff will rely on th	at the inform is information and my dentis	nation on fo st, or	n give or trea any	en on this form is accurate. I understand the importance of a truthful h ating me. I acknowledge that my questions, if any, about inquiries set other member of his/her staff, responsible for any action they take or d	forth	1		
Signature of Patient/Legal Guardian:				Date:				
	FOR CO	MP	LETI	ON BY DENTIST				
Comments:								