Health History Form

ADA American Dental Association®

America's leading advocate for oral health

Agreement by law, our office adheres to written polices and procedures to protect the privacy of information about you that we create, necessor or marriain. Your answers are for our costs only and will be large confidentials silent to applicable laws. Picker ends that you will be soled some questions about you unreptones to this questionness and their may be disclosed agents occurred to the large control and the process of the privacy of the following decessors occurred to the process occurred to the proc	Email:								
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SSP or Patient ID:	Mailing address								
If you are completing this form for another person, what is your relationship to that person? The Name	Occupation:			Height:	Weight:	Date of Birth:		Sex: M F	
Do you have any of the following diseases or problems: (Check DK if you Don't Know the answer to the the question) Yes No DK 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. Yes 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 earaches or neck pains? Do you have earaches or neck pains? Do you have any clicking, popping or disconflort in the jaw? By your mouth dry? Have you had any problems associated with previous dental treatment? Do you whave derturnes or partials? Do you whave derturnes or partials? Do you whave serve routers in your mouth? Do you whave serve routers in your service? Do you whave serve routers in your service? Do you whave serve routers in your service? Do you whave service in your service? Do you whave service your service? Do you whave se	SS# or Patient ID:	Emergency Contac	ct:	Relationship:	Home Phone:	Include area code	Cell Phone:	Include area code	
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Are your teeth sensitive to cold, hot, sweets or pressure?			Yes No DK						
Is your mouth dry?	Do your gums bleed when yo	u brush or floss?	00	Do you have earaches or neck pains?					
Have you had any periodontal (gum) treatments?									
Have you ever had orthodontic (braces) treatment?	Is your mouth dry?	?							
Have you had any problems associated with previous dental treatment?	Have you had any periodonta	ou had any periodontal (gum) treatments?							
Is your home water supply fluoridated? Have you ever had a serious injury to your head or mouth? Date of your last dental exam: What was done at that time? What was done at that time? Date of last dental exam: What was done at that time? Date of last dental x-rays: What is the reason for your dental visit today? Date of last dental x-rays: What is the reason for your dental visit today? What was done at that time? Date of last dental x-rays: What is the reason for your dental visit today? What was done at that time? Date of last dental x-rays: What is the reason for your dental visit today? What was done at that time? Date of last dental x-rays: What is the reason for your dental visit today? What was done at that time? What was done at that time? Date of last dental x-rays: What is the reason for your dental visit today? What was done at that time? What was done at that time? Date of last dental x-rays: What was done at that time? Date of last dental x-rays: What was done at that time? What was done at that time? Date of last dental x-rays: What was done at that time? Date of last dental x-rays: What was done at that time? Date of last dental x-rays: What was done at that time? Date of last dental x-rays: Date of last dental x-rays: What was done at that time? Date of last dental x-rays: Date of last dental x-ra	Have you ever had orthodont	you ever had orthodontic (braces) treatment?			그게 되는 그림을 하는 것이 되었다. 나는 사람이 아무리				
Do you drink bottled or filtered water? Date of your last dental exam: What was done at that time? 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 Are you now under the care of a physician? Phone: Include area code (I) The past 5 years? The your 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? The you have you recently taken any prescription or over the counter medicine(s)? The years? The yea									
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY Are you currently experiencing dental pain or discomfort?	Is your home water supply flu								
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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 Are you now under the care of a physician? Phone: Include area code () Address/City/State/Zip: Are you in good health? Are you in good health? Are you general health within the past year? If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements: If yes, what condition is being treated?	If yes, how often? Circle one:	DAILY / WEEKLY / OCCAS	IONALLY	What was done at t	hat time?				
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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 use controlled substances (drugs)? Do you wear contact lenses?. 000 Joint Replacement. Have you had an orthopedic total joint Do you use tobacco (smoking, snuff, chew, bidis)? (hip, knee, elbow, finger) replacement? If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED Date: ______ If yes, have you had any complications? ____ Do you drink alcoholic beverages? Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax*, Actonel*, Atelvia, Boniva*, Reclast, Prolia) for If yes, how much alcohol did you drink in the last 24 hours? osteoporosis or Paget's disease?... 000 If yes, how much do you typically drink in a week? _____ Since 2001, were you treated or are you presently scheduled to begin WOMEN ONLY Are you: treatment with an antiresorptive agent (like Aredia*, Zometa*, XGEVA) Pregnant?. for bone pain, hypercalcemia or skeletal complications resulting from Number of weeks: _ Paget's disease, multiple myeloma or metastatic cancer?..... 000 Taking birth control pills or hormonal replacement? Date Treatment began: Nursing?.. Allergies. Are you allergic to or have you had a reaction to: Ves No DK To all yes responses, specify type of reaction. Yes No DK 000 Metals Local anesthetics Latex (rubber) Aspirin 000 _____ Iodine Penicillin or other antibiotics Barbiturates, sedatives, or sleeping pills 000 Animals ____ 🗆 🗆 🗆 000 Sulfa drugs ____ 000 Codeine or other narcotics 000 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 Glaucoma Autoimmune disease..... Artificial (prosthetic) heart valve..... Hepatitis, jaundice or liver disease..... Rheumatoid arthritis...... Previous infective endocarditis Damaged valves in transplanted heart Systemic lunus erythematosus...... Epilepsy Congenital heart disease (CHD) Unrepaired, cyanotic CHD...... Asthma Fainting spells or seizures Neurological disorders 🗆 🗆 🗆 Bronchitis Repaired (completely) in last 6 months...... If yes, specify:_____ Emphysema...... Repaired CHD with residual defects Sleep disorder Sinus trouble Do you snore?..... Except for the conditions listed above, antibiotic prophylaxis is no longer recommended Tuberculosis..... for any other form of CHD. Mental health disorders...... Cancer/Chemotherapy/ Specify: ___ Radiation Treatment..... Yes No DK Yes No DK Recurrent Infections Chest pain upon exertion...... Cardiovascular disease...... Mitral valve prolapse..... Type of infection: Chronic pain Angina...... Pacemaker..... Kidney problems...... Diabetes Type I or II 🗆 🗆 🗆 Arteriosclerosis..... Rheumatic fever...... Night sweats Congestive heart failure...... Eating disorder Rheumatic heart disease...... Osteoporosis...... Malnutrition Damaged heart valves Persistent swollen glands in neck...... Abnormal bleeding Gastrointestinal disease...... Heart attack Anemia Severe headaches/ G.E. Reflux/persistent Heart murmur...... Blood transfusion...... migraines...... Low blood pressure If yes, date: Severe or rapid weight loss Ulcers Hemophilia High blood pressure..... Sexually transmitted disease.. Thyroid problems AIDS or HIV infection...... Other congenital Excessive urination heart defects..... 0 0 0 Arthritis Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Name of physician or dentist making recommendation: Phone: Include area code () Do you have any disease, condition, or problem not listed above that you think I should know about? 000 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. Signature of Patient/Legal Guardian: Date: Signature of Dentist: Date FOR COMPLETION BY DENTIST Comments: