

Health History Form

Name _____ Preferred Name _____

First

Middle

Last

SS# _____ E-mail _____

Home Phone (_____) _____ Cell (_____) _____ Work (_____) _____

Address _____ City _____ State _____ Zip Code _____

Emergency Contact/Relationship _____ Phone (_____) _____

Weight _____ Date of Birth _____ Sex M F Marital Status _____

Spouse's Name _____ Who referred you to our practice? _____
Name Relationship

INSURANCE INFORMATION

INSURED PERSON'S FULL NAME RELATIONSHIP INSURED PERSON D.O.B SUBSCRIBER I.D.#

INSURED'S EMPLOYER NAME INSURANCE COMPANY NAME GROUP NUMBER

DENTAL INFORMATION

YES	NO	UNSURE		YES	NO	UNSURE	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do your gums bleed when you brush?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had orthodontic treatment?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are your teeth sensitive to cold, hot, sweets, or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have headaches, earaches or neck pains?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear removable dental appliances?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any problems with previous dental treatment? If so, explain _____				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been told you require antibiotics before dental appointments?				

How would you describe your current dental problem? _____

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

What was done at that time? _____

How do you feel about the appearance of your teeth? _____

MEDICAL INFORMATION

YES	NO	UNSURE	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you in good health?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have there been any changes in your health within the past year? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you under the care of a physician? If so, what are the conditions being treated? _____

Date of last exam _____

Physician(s) _____

Name Phone Address City/State/Zip

Name Phone Address City/State/Zip

Have you ever had a serious illness, operation, or been hospitalized in the past five years? Explain _____

Are you pregnant or nursing?

Do you drink alcoholic beverages? If yes, how many drinks did you have in the past week? _____ month? _____

Are you alcohol and/or drug dependent? (check one) YES NO If so have you received treatment? _____

Do you use tobacco (smoking or chew)? If so, how interested are you in quitting? Very Somewhat Not at all
How many years have or did you use tobacco? _____ How much per day? _____

Are you taking any medications? If yes, for what purposes? PLEASE LIST BELOW

NAME OF DRUG	PURPOSE	DOSE

YES NO UNSURE

Are you allergic to or have you had a reaction to:

Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Iodine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever/seasonal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please (x) a response to indicate if you have or have had any of the following diseases or problems

	YES	NO	UNSURE		YES	NO	UNSURE
Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, Jaundice, or Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, indicate type of infection_____			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion If yes, date_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Chemotherapy/Radiation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular diseases? If yes, please specify with date	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina Pectoris _____				Persistent swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur _____				Respiratory problems. If yes, please specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bypass Surgery _____				___ Emphysema ___ Bronchitis, etc.			
Mitral Valve Prolapse _____				Severe headaches/migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker _____				Severe or rapid weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever _____				Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Valves _____				Sores or ulcers in the mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack _____				Stroke. If yes, date_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	YES	NO	UNSURE	Systemic Lupus Erythematosus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain upon exertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disease, drug, or radiation-induced immunosuppression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes. If yes, please specify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Insulin dependent ___ Non-Insulin dependent				Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any disease not listed above	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder. If yes, please specify_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Please Explain:_____			
Fainting spells or seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Gastrointestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
G.E. reflux/persistent heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

I certify that I have read and understand the above. 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 because of errors or omission that I may have made in the completion of this form.

SIGNATURE OF PATIENT/LEGAL GUARDIAN

DATE

Date	Comments/Changes	Signature of patient	Signature of Dentist
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____