Health History Form

ADA American Dental Association®

America's	loading	advacata	for oral	hoalth
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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 answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Ves No DK Po your gums bleed when you brush or floss?	Name:					Home Phone: Inc	lude area code	Business/Cell Phone: Inclu	de area code	9
Address Maling adeas. Cocupation: Height: Weight: Dute of birth: Sex M F SSR or Patient ID: Emergency Contact: Relationship to that person? Sort American Completing this form for another person, what is your relationship to that person? Now have any of the following diseases or problems: (Check DK If you Don't Know the answer to the question) They have any of the following diseases or problems: (Check DK If you Don't Know the answer to the question) Persistent cough preater than a 3 week duration Coughi that produces blood Been exposed to anyone with tuberculosis. Persistent cough preater than a 3 week duration Coughi that produces blood Been exposed to anyone with tuberculosis. Persistent cough preater than a 3 week duration Coughi that produces blood Deem that it you answer yet 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. Dental Information For the following questions, please mark (X) your responses to the following questions. Dental Information For the following questions, please mark (X) your responses to the following questions. Ves. No. DK Do you have early clicking, popping or disconfort in the jaw? Do you have any clicking, popping or disconfort in the jaw? Do you have any clicking, popping or disconfort in the jaw? Do you have any clicking, popping or disconfort in the jaw? Have you have any clicking, popping or disconfort in the jaw? Place you have any clicking, popping or disconfort in the jaw? Have you have any clicking, popping or disconfort in the jaw? What is the reason for fost of the following discassos or problems: 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? What is the reason for your dental visit today? What is the reason for your dental visit today? If yes, what was the illness or problem? Are you taking or have you	Last	First	Middle		()		()			
Active Discourage of Patient ID: Emergency Contact: Relationship: Home Phone: Cel Phone: New Year Cell Phone: New Yea	Address:	ividue			City:		State:	Zip:		
Declaration: Height Weight Date of birth: Sec M F	Mailing address	las conscience for any								
Sit or Patient ID: Emergency Contact: Relationship: Home Phone: Cell Phone: Ce						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? **Nor Hance** **Do you have any of the following diseases or problems: **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 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 of the following questions.** **Yes No DK DK you have any clicking, popping or discomfort in the jaw?** **Pool to the sensitive to cold, hot, sweets or pressure?** **Do you have any clicking, popping or discomfort in the jaw?** **Pool to the sensitive to cold, hot, sweets or pressure?** **Do you have any clicking, popping or discomfort in the jaw?** **Pool to the sensitive to cold, hot, sweets or pressure?** **Do you have any clicking, popping or discomfort in the jaw?** **Pool to the sensitive to cold, hot, sweets or pressure?** **Do you have any clicking, popping or discomfort in the jaw?** **Have you have any clicking, popping or discomfort in the jaw?** **Hav						3		169	Jex. 1	sal are
If you are completing this form for another person, what is your relationship to that person? **Nor Hance** **Do you have any of the following diseases or problems: **Check DK if you Don't Know the answer to the question)** **Check DK if you Don't Know the answer to the question)** **Cough that produces blood.** **Cough that produces blood.** **Cough that produces blood.** **Persolatent cough greater than a 3 week duration	SS# or Patient ID:	Emergency Contact:				Relationshin:		Jama Phana: Call	Phone	
If you are completing this form for another person, what is your relationship to that person? **Sort Name**						riciationship.	() ()	
Den tal Information For the following guestions, please mark (X) your responses to the following questions. Yes No Dispose food of fost earth and gump treatments? Do you have earaches or neck pains? Do you on the third your files and you file of the following questions, please mark (X) your responses to the following questions. Yes No Dispose food of fost earth pains your files and you file of the following questions are going to grant the following questions. Do you have earaches or neck pains? Do you have earaches or neck pains? Do you have earaches or neck pains? Yes No Dispose food of fost earth pathwers you be provided from your files and you file for fi	If you are completing this form for a		1	F				Include area codes	and the	
Do you have any of the following diseases or problems: Check DK if you Don't Know the answer to the question		other person, what is your	relatio	onsn	ip to	that person?				
Active Tuberculosis. Persistent couply greater than a 3 week duration. Cough that produces blood. Been exposed to anyone with tuberculosis. Per you answer yes to any of the 4 items above, please stop and return this form to the receptionist. Cough that produces blood.								alia mayale ta asan		
Cough that produces blood. 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 (XI your responses to the following questions. Ves No DK Do you gums bleed when you brush or floss? Are your teeth sensitive to cold, hot, sweets or pressure? Do you brush or gind your teeth? Do you have any clicking, popping or discomfort in the jaw? Do you brush or gind your teeth? Do you ware dentures or partials? Have you are dentures or partials? Have you are dentures or partials? Do you participate in active recreational activities? Have you had any problems associated with previous dental treatment? Do you have or have not had a serious injury to your head or mouth? 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? What is the reason for your dental visit today? What is the reason for your dental visit today? What was done at that time? 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? What was done at that time? 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? Are you now under the care of a physician? Are you now under the care of a physician? Are you in good healt	Active Tuberculosis								П	No Di
Been exposed to anyone with tuberculosis.	Persistent cough greater than a 3 wee	k duration							П	
Dental Information for the following questions, please mark (X) your responses to the following questions. Ves No DK	Cough that produces blood							*		
Dental Information For the following questions, please mark (X) your responses to the following questions. Yes No DK Yes No DK Do your gums bleed when you brush or floss?	Been exposed to anyone with tubercul	losis								
Ves No DK Yes No DK Are your gums bleed when you brush or floss?	If you answer yes to any of the 4 I	tems above, piease stop	o and	retu	rn th	his form to the re	ceptionist.	.84		
Ves No DK Yes No DK Are your gums bleed when you brush or floss?	Dontal Information									
Ves No DK Yes No DK Are your gums bleed when you brush or floss?	Jental Information	For the following question	ons, ple	ease	mark	k (X) your response	s to the follow	ving questions.		
Are you reeth sensitive to cold, hot, sweets or pressure?			Yes	No					Yes	No DI
Are you reeth sensitive to cold, hot, sweets or pressure?	Do your gums bleed when you brush o	or floss?	🗆			Do you have earaches or neck pains?				
Is your mouth dry?										
Is your mouth dry?	Does food or floss catch between your	r teeth?	🗆			Do you brux or grind your teeth?				
Have you had any periodontal (gum) treatments?	Is your mouth dry?		🗆			Do you have sores or ulcers in your mouth?				
Have you ever had orthodontic (braces) treatment?						Do you wear dentures or partials?				
Have you had any problems associated with previous dental treatment?			🗆			Do you participa	te in active re	creational activities?		
treatment? Date of your last dental exam: What was done at that time? Date of last dental exam: What was done at the past dental exam: What was dental e										
What was done at that time? Do you drink bottled or filtered water?										
Do you drink bottled or filtered water?										
Are you now under the care of a physician? 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			🗆				ar that time.			
What is the reason for your dental pain or discomfort?						Date of last dent	al x-rays			
How do you feel about your smile? Vedical 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 had a serious illness, operation or been hospitalized in the past 5 years?	Are you currently experiencing dental p	pain or discomfort?	🗆			a de or idat derit	an x rays.			
Are you in good health?	What is the reason for your dental visit	today?								
Are you in good health?	How do you feel about your smile?									
Are you now under the care of a physician?	now do you reel about your smile?					i araka araka lines a				
Are you now under the care of a physician?								SOURCE CONTRACTOR SECTION SECT		
Are you now under the care of a physician?										
Are you now under the care of a physician?	Medical Informatio	n Please mark (X) your re	espons	e to	indic	ate if you have or	have not had	any of the following diseases or	problem	5
Are you now under the care of a physician?			Yes	No	DK			, , , , , , , , , , , , , , , , , , , ,		
Physician Name: Phone: Include area code () Address/City/State/Zip: Are you in good health? Has there been any change in your general health within the past year? If yes, what condition is being treated? 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)? If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:	Are you now under the care of a physic	cian?	🗆			Have you had a	serious illness	operation or been	163	NO DI
Are you in good health?	Physician Name:	Phone: Incl	ude area	code					П	
Are you in good health?										The state of
Are you in good health?	Address/City/State/Zip:					100 301 HQUAR 150	e en et arc salsi	That there is made the street and the		
Are you in good health?	Lors do su salut yard noune y a sel					Are the state of	COOK TOO NOT	The last in the street answers.		
Has there been any change in your general health within the past year?	Are you in good health?								To expect	2 9 ES
the past year? and/or diet supplements:			🗀		ш					
If yes, what condition is being treated?								itamins, natural or herbal prepai	rations	
						ariu/or uiet suppi	ements:			
Date of last physical exam:	yes, what condition is being treated?								-	
Date of last physical exam:										
	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 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 yes, 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. Metals Local anesthetics_ Latex (rubber) Aspirin lodine Penicillin or other antibiotics_____ Hay fever/seasonal Barbiturates, sedatives, or sleeping pills Animals_____ Sulfa drugs Food translation to seesacits unionable) will be sees on a supply 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 Artificial (prosthetic) heart valve..... Autoimmune disease Hepatitis, jaundice or Previous infective endocarditis liver disease Rheumatoid arthritis Damaged valves in transplanted heart Systemic lupus erythematosus. Epilepsy Congenital heart disease (CHD) ngenital heart disease (CHD) Unrepaired, cyanotic CHD...... Asthma..... Fainting spells or seizures...... Neurological disorders..... Bronchitis..... Repaired (completely) in last 6 months Emphysema If yes, specify:____ Repaired CHD with residual defects Sinus trouble Sleep disorder..... Tuberculosis Mental health disorders Except for the conditions listed above, antibiotic prophylaxis is no longer recommended Cancer/Chemotherapy/ for any other form of CHD. Recurrent Infections...... Radiation Treatment Yes No DK Yes No DK Chest pain upon exertion \square \square Type of infection:_____ Chronic pain Kidney problems Pacemaker Diabetes Type I or II........ Night sweats..... Arteriosclerosis Rheumatic fever Eating disorder..... Osteoporosis...... Congestive heart failure Rheumatic heart disease...... Malnutrition..... Persistent swollen glands Damaged heart valves...... Abnormal bleeding Gastrointestinal disease...... Heart attack...... Anemia...... Severe headaches/ G.E. Reflux/persistent Heart murmur Blood transfusion heartburn migraines Low blood pressure..... If yes, date:_____ Ulcers Severe or rapid weight loss High blood pressure..... □ □ □ Hemophilia Thyroid problems Sexually transmitted disease Other congenital heart AIDS or HIV infection Stroke..... Excessive urination..... defects Arthritis Glaucoma Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Name of physician or dentist making recommendation: Phone: 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. Signature of Patient/Legal Guardian: Date: FOR COMPLETION BY DENTIST Comments: