Health History Form

Date ______________

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	
☐	☐	☐	Do your gums bleed when you brush?
☐	☐	☐	Are your teeth sensitive to cold, hot, sweets, or pressure?
☐	☐	☐	Have you had any periodontal (gum) treatments?
☐	☐	☐	Have you had any problems with previous dental treatment? If so, explain ______________
☐	☐	☐	Have you ever been told you require antibiotics before dental appointments?
☐	☐	☐	Have you ever had orthodontic treatment?
☐	☐	☐	Do you have headaches, earaches or neck pains?
☐	☐	☐	Do you wear removable dental appliances?

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	
☐	☐	☐	Are you in good health?
☐	☐	☐	Have there been any changes in your health within the past year? ______________
☐	☐	☐	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

YES	NO	UNSURE	
☐	☐	☐	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

Are you allergic to or have you had a reaction to:	YES	NO	UNSURE
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa Drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Latex	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Other (specify)________________________	☐	☐	☐

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

	YES	NO	UNSURE
Abnormal Bleeding	☐	☐	☐
AIDS or HIV	☐	☐	☐
Anemia	☐	☐	☐
Arthritis	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐
Asthma	☐	☐	☐
Blood transfusion If yes, date_________________	☐	☐	☐
Cancer/Chemotherapy/Radiation	☐	☐	☐
Cardiovascular diseases? If yes, please specify with date	☐	☐	☐
Angina Pectoris_________________			
Heart Murmur _________________			
Bypass Surgery_________________			
Mitral Valve Prolapse_____________			
Pacemaker _________________			
Rheumatic Fever_________________			
Artificial Valves _________________			
Heart Attack_________________			

	YES	NO	UNSURE
Chest Pain upon exertion	☐	☐	☐
Chronic Pain	☐	☐	☐
Disease, drug, or radiation-induced immunosuppression	☐	☐	☐
Diabetes. If yes, please specify	☐	☐	☐
____Insulin dependent ____ Non-Insulin dependent			
Dry mouth	☐	☐	☐
Eating disorder. If yes, please specify______________	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Gastrointestinal Disease	☐	☐	☐
G.E. reflux/persistent heartburn	☐	☐	☐
Glaucoma	☐	☐	☐

	YES	NO	UNSURE
Hemophilia	☐	☐	☐
Hepatitis, Jaundice, or Liver Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
Recurrent Infection	☐	☐	☐
If yes, indicate type of infection_____________________________			
Mental Health disorder	☐	☐	☐
Night Sweats	☐	☐	☐
Neurological disorders	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands	☐	☐	☐
Respiratory problems. If yes, please specify:	☐	☐	☐
___Emphysema ___Bronchitis, etc.			
Severe headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sinus Trouble	☐	☐	☐
Sores or ulcers in the mouth	☐	☐	☐
Stroke. If yes, date_________________	☐	☐	☐
Systemic Lupus Erythematosus	☐	☐	☐
Tuberculosis	☐	☐	☐
Thyroid problems	☐	☐	☐
Ulcers	☐	☐	☐
Excessive urination	☐	☐	☐
Joint replacement	☐	☐	☐
Do you have any disease not listed above	☐	☐	☐

Please Explain:____

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