HEALTH HISTORY

To help us ensure continuity between medical and dental care, we would appreciate your cooperation in completing this questionnaire. Since disorders of the mouth are so often interrelated with other physical conditions, the information you provide is important in arriving at a dental diagnosis, and in identifying any precautionary measures we may need to take to protect your health. If there are any questions you have difficulty in answering, or if you wish to include additional information, please bring this to the doctor's attention. This information is, of course, strictly confidential and will become part of your personal dental records.

Please answer all questions by *circling* *"NO"* or *"YES"* and fill in blank spaces when indicated.

Name _____ Age _____ Birthdate _____

Address _____City_____St_____ZIP_____ Home Telephone_____

Employer _____ Business Telephone _____ Cell Telephone_____

Occupation _____ Marital Status: ❑ single ❑ married ❑ widowed ❑ divorced

Who may we thank for referring you to us? _____

What is your major dental problem or reason for the present visit? _____

_____

Do you have a physician? ..... No Yes

Physician's Name _____ Physician's Telephone _____

Physician's Address _____

When did you last visit your physician? Reason? _____

What conditions or problems are you being treated for? _____

Whom should we contact in the event of an emergency (closest relative)? _____

Business Telephone _____ Home Telephone _____

Address _____

Have you ever been hospitalized, had any serious illness, or had any operations? ..... No Yes

If yes, list problem and dates: _____

_____

Are you presently taking any drug or medication? *If so, please list:* ..... No Yes

	Medication	***Dose (strength)***	***When taken***
1.			
2.			
3.			
4.			
5.			
6.			

This is the first of four pages, please answer all questions on the remaining pages.

Have you taken *any* of the following drugs or medications *in the past year*?

Cortisone or steroids? ..... No Yes
Medication for high blood pressure or "water pills"? ..... No Yes
Anticoagulants ("blood thinners")? ..... No Yes

Tranquilizers, sedatives, or sleeping pills? ..... No Yes
Aspirin? ..... No Yes
Insulin or pills for diabetes? ..... No Yes

Digitalis, nitroglycerine, or drugs for heart trouble? ..... No Yes
Amphetamines? ..... No Yes
Dilantin or anti-convulsant medications? ..... No Yes

Birth control pills? ..... No Yes
Antihistamines? ..... No Yes
Narcotics? ..... No Yes

Hormones? ..... No Yes
Cocaine, Marijuana, crystal methamphetamine or other illicit drugs? ..... No Yes
Any other pills, tablets, liquids, or medications not listed on previous page? ..... No Yes
If yes, please list: _____

Do you smoke? ..... No Yes

What? _____ *How many per day?* _____ *How many years?* _____

Do you ever drink alcoholic beverages? ..... No Yes

What? _____ *How often?* _____ *How many years?* _____

Have you ever had a bad reaction to:

Local anesthetics, dental anesthetics, or "novocaine"? ..... No Yes
Penicillin or other antibiotics? ..... No Yes
Codeine, other narcotics, or pain killers? ..... No Yes

Iodine? ..... No Yes
Sedatives, tranquilizers, or sleeping pills? ..... No Yes
General anesthesia, nitrous oxide ("gas"), or injections? ..... No Yes

Are you allergic to any drugs or medications? ..... No Yes
If yes, to what? _____

Do you have any other allergies? ..... No Yes
If yes, to what? _____

Are you allergic or sensitive to latex or natural rubber? ..... No Yes

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS:

1. Frequent headaches? ..... No Yes
2. Weight loss or gain of more than ten pounds recently? ..... No Yes
3. Cancer or tumors? ..... No Yes
4. Soreness or swelling under your jaw, arms, or any other part of your body? ..... No Yes
5. Surgery or radiation (x-ray) treatment for a growth, tumor, cancer, or other condition of the head, neck, or mouth? ..... No Yes
6. Fever blisters or "cold sores"? ..... No Yes
7. Recurrent canker sores, mouth ulcers, or oral herpes infections? ..... No Yes
8. Frequent dry mouth? ..... No Yes

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS:

9. Clicking, popping, or other sounds from the ears or jaw joints? ..... No Yes
10. Persistent or recurring pain, soreness, or stiffness in the face, head, or neck? ..... No Yes
11. Jaw joint (TMJ) problems or treatments? ..... No Yes
12. Do you wear any type of dental appliance? ..... No Yes
13. Bleeding gums, or blood on your toothbrush? ..... No Yes
14. Teeth that are sensitive to heat, cold, or chewing? ..... No Yes
15. Difficulties with past dental work or treatment? ..... No Yes
    If so, please explain: _____
16. Have you lost any teeth? ..... No Yes
    If so, why? _____
17. Skin problems, rashes, hives, or eruptions? ..... No Yes
18. Sinus pain or sinus trouble? ..... No Yes
19. Any hearing problems, visual problems, or other disability or handicap we should know about or consider in planning your dental treatment? ..... No Yes
    If so, please explain: _____
20. Hayfever? ..... No Yes
21. Asthma, Emphysema or difficulty in breathing? ..... No Yes
22. Lung problems, infections, or tuberculosis? ..... No Yes
23. Persistent cough or coughing up blood? ..... No Yes
24. Rheumatic fever, rheumatic heart disease, scarlet fever, or bacterial endocarditis? ..... No Yes
25. Heart murmur, congenital heart disease, mitral valve prolapse, abnormal or unusual heart sounds? No Yes
26. Heart trouble, heart attack, coronary insufficiency angina, or aortic stenosis? ..... No Yes
27. Heart surgery, pacemaker, artificial/replacement heart valve, or artificial blood vessels? ..... No Yes
28. High blood pressure (hypertension)? ..... No Yes
29. Shortness of breath when you lie down or sleep? ..... No Yes
30. Shortness of breath, chest pain or pressure sensation after mild exercise? ..... No Yes
31. Hepatitis, jaundice or liver disease? ..... No Yes
32. Stomach ulcers or gastrointestinal ulcers? ..... No Yes
33. Kidney trouble or renal dialysis? ..... No Yes
34. Venereal disease, gonorrhea, syphilis, or other? ..... No Yes
35. Positive blood test for HIV, pre-AIDS, ARC, or AIDS? ..... No Yes
36. Excessive thirst? ..... No Yes
37. Frequent urination (pass water more than six times a day)? ..... No Yes
38. Diabetes, hypoglycemia, or other blood sugar problems? ..... No Yes
39. Thyroid disease or goiter? ..... No Yes
40. Arthritis or frequent joint pains? ..... No Yes
41. Artificial joints or bones (prosthesis) implanted? Example: Hip, Knee ..... No Yes

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS:

42. Large bruises (the size of your palm or larger) that seem to occur by themselves? ..... No Yes
43. Blood disorders, anemia, Sickle cell anemia, or Sickle cell disease? ..... No Yes
44. Difficulty or prolonged bleeding following tooth extraction? ..... No Yes
45. Excessive bleeding after an injury or surgery, or other bleeding problems? ..... No Yes
46. Have you ever received a blood transfusion? ..... No Yes
47. Have you ever been denied permission to donate blood? ..... No Yes
48. Are you exposed to x-rays or other forms of ionizing-radiation as part of your work? ..... No Yes
49. Have you ever been in intimate contact with any individual having hepatitis, tuberculosis, HIV infection, AIDS, or venereal diseases? ..... No Yes
50. Has anyone in your family had diabetes, blood sugar problems, heart disease, or immunological diseases (such as lupus)? ..... No Yes
51. Seizures or convulsions ("fits" or "falling out")? ..... No Yes
52. Fainting, dizzy spells, stroke (C.V.A.) , or mini-stroke (T.I.A.) ? ..... No Yes
53. Are you apprehensive or very nervous about dental treatment? ..... No Yes
54. Have you ever received tranquilizers or sedatives for dental procedures? ..... No Yes
55. Nervous disorders, depression, psychotherapy or psychiatric treatment? ..... No Yes
56. Other condition, problem, or disease not listed above that you feel we should know about? ..... No Yes

    If yes, what? _____

57. Do you have any problems associated with your menstrual period? ..... No Yes
58. Are you breast-feeding a baby? ..... No Yes
59. Are you pregnant, possibly pregnant, or anticipating pregnancy in the near future? ..... No Yes
60. Are you taking any bis-phosphonate drugs for osteoporosis? Example: Fosamax, Boniva, Actonel…….... No Yes
61. Are you aware of an enlarged prostate or difficulty with urination? ..... No Yes

THE INFORMATION ON THE ABOVE HEALTH HISTORY FORM HAS BEEN FURNISHED BY ME, AND IS ACCURATE, COMPLETE, AND TRUE TO THE BEST OF MY KNOWLEDGE.

Date: _____ Patient's signature: _____

Doctor's signature: _____

If you are completing this form for another person, what is your relationship to that person? _____

Please do not write below this line.

I have reviewed the above health history, and no changes have occurred since the above date, except as described below:

_____

_____

_____

Date: _____ Patient's signature: _____