NEW PATIENT HEALTH HISTORY FORM

Date:

Last Name: First Name: Birthdate:

Emergency Contact: Phone: Relationship:

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.

Dental Information

(For the following questions, please mark(X) your responses to the follwing questions.)

	Y	N
Do your gums bleed when you brush or floss?	☐	☐
Are your teeth sensitive to cold, hot, sweets, or pressure?	☐	☐
Is your mouth dry?	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐
Is your home water supply fluoridated?	☐	☐
Do you drink bottle or filtered water?	☐	☐
If yes, how often?		
Are you currently experiencing dental pain or discomfort?	☐	☐
Do you have earaches or neck pains?	☐	☐
Do you have any clicking, popping, or discomfort in the jaw?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you have sore or ulcers in your mouth?	☐	☐
Do you wear dentures or partials?	☐	☐
Do you participate in active recreational activities?	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐

Date of your last dental exam:

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.)

	Y	N
Are you now under the care of a physician?	☐	☐

Physician Name: Physician Phone:

Address/City/State:

	Y	N
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?		
Date of last physical exam:		
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐
If yes, what was the illness or problems?		
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐
If yes, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:		

	Y	N
Do you wear contact lenses?	☐	☐
Joint Replacement.		
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐
Date: If yes, have you had any complications?		
Are you taken or schedule to begin taking an antiresorptive agent (like Fosamax, Actonel, Boniva, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐
Since 2001, were you treated or are you presently, schedule to beging treatment with an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalmia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐
Date Treatment began:		
Do you use controlled sudstances (drugs)?	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐
If yes, how intereted are you in stopping?		
Do you drink alcohol beverage?	☐	☐
If yes, explain		

Women Only	Y	N
Are you pregnant?	☐	☐
If yes, number of weeks		
Are you taking birth control pills or hormonal replacement?	☐	☐
Are you nursing?	☐	☐

Allergies.

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

Y	N		Y	N	
☐	☐	Local anesthetic	☐	☐	Iodine
☐	☐	Aspirin	☐	☐	Latex (rubber)
☐	☐	Codeine or othernarcotics	☐	☐	Penicillin or other antibiotics
☐	☐	Ibuprofen	☐	☐	Seasonal
☐	☐	Barbiturantes, sedatives, or sleeping pills	☐	☐	Food
☐	☐	Sulfa drugs	☐	☐	Other

(To all yes responses, specify type of reaction.)

Health Problems (Please mark (x) your response to indicate if you have or have not had any of the following diseases or problems.)

	Y	N
Artificial (prosthetic) heart valve	☐	☐
Previous infective endocarditis	☐	☐
Damaged valves in transplanted heart	☐	☐
Congenital heart disease (CHD):		
Unrepaired, cyanotic CHD	☐	☐
Repaired (completely) in last 6 months	☐	☐
Repaired CHD with residual defects	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD

Y	N		Y	N	
☐	☐	Cardiovascular disease	☐	☐	Mitral valves prolapse
☐	☐	Angina	☐	☐	Pacemaker
☐	☐	Arteriosclerosis	☐	☐	Rheumatic heart disease
☐	☐	Congestive heart failure	☐	☐	Rheumatic Fever
☐	☐	Damaged heart valves	☐	☐	Abnormal bleeding
☐	☐	Heart Murmur	☐	☐	Anemia
☐	☐	Heart attack	☐	☐	Blood transfusion (if yes,date)
☐	☐	High blood pressure			
☐	☐	Low blood pressure	☐	☐	Hemophilia
☐	☐	Other congenital heart defects (specify)	☐	☐	AIDS or HIV infection
			☐	☐	Arthritis

Y	N		Y	N	
☐	☐	Autoimmune disease	☐	☐	Glaucoma
☐	☐	Rheumatoid arthritis	☐	☐	Hepatitis, jaundice or liver disease
☐	☐	Systemic lupus erythematosus	☐	☐	Epilepsy
☐	☐	Asthma	☐	☐	Fainting spells or seizures
☐	☐	Bronchitis	☐	☐	Neurological disorders (if yes, specify)
☐	☐	Emphysema			
☐	☐	Sinus trouble	☐	☐	Do you snore?
☐	☐	Tuberculosis	☐	☐	Mental health disorders (specify)
☐	☐	Cancer/Chemotherapy/Radiation treatment			
☐	☐	Chest pain upon exertion	☐	☐	Sleep disorder
☐	☐	Chronic pain	☐	☐	Recurrent infections (type of infection:)
☐	☐	Diabetes Type I			
☐	☐	Diabetes Type II	☐	☐	Kidney problems
☐	☐	Eating disorder	☐	☐	Night sweats
☐	☐	Malnutrition	☐	☐	Osteoporosis
☐	☐	Gastrointestinal disease	☐	☐	Persistent swollen glands in neck
☐	☐	G.E. Reflux/persistent heartburn	☐	☐	Severe headaches/migraines
☐	☐	Ulcers	☐	☐	Severe or rapid weight loss
☐	☐	Thyroid problems	☐	☐	Sexually transmitted disease
☐	☐	Stroke	☐	☐	Excessive urination

☐ ☐ 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 understand the above and that the information given on this form is accurate. I understand the importance of an honest health history and that my dentist and his/her staff will rely on this information for my treatement. I acknowledge that my questions, if any, about inquiries set forth will be 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

Signature of Dentist