Health History Form

ADA®
American Dental Association
www.ada.org

E-mail: Today's Date:

REF:_____

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.

Name:	Home Phone: *Include area code*	Business/Cell Phone: *Include area code*
Last First Middle	( )	( )

Address:	City:	State:	Zip:
Mailing address			

Occupation:	Height:	Weight:	Date of birth:	Sex: M F

Emergency Contact:	Relationship:	Home Phone: ( )	Cell Phone: ( )
			Include area codes

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

Your Name   Relationship

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood..	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

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 (X) your responses to the following questions.*

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐	Do you have earaches or neck pains?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐	Do you have any clicking, popping or discomfort in the jaw?....	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐	Do you brux or grind your teeth?	☐	☐	☐
Is your mouth dry?...	☐	☐	☐	Do you have sores or ulcers in your mouth?..............................	☐	☐	☐
Have you had any periodontal (gum) treatments?.......................	☐	☐	☐	Do you wear dentures or partials?...	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐	Do you participate in active recreational activities?	☐	☐	☐
Have you had any problems associated with previous dental treatment?...	☐	☐	☐	Have you ever had a serious injury to your head or mouth?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐	Date of your last dental exam: What was done at that time?			
Do you drink bottled or filtered water?.......................................	☐	☐	☐				
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY Are you currently experiencing dental pain or discomfort?..........	☐	☐	☐	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.*

	Yes	No	DK		Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐	Have you had a serious illness, operation or been hospitalized in the past 5 years?...	☐	☐	☐
Physician Name: Phone: *Include area code* ( )				If yes, what was the illness or problem?			
Address/City/State/Zip:							
Are you in good health?	☐	☐	☐	Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐	If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:			
If yes, what condition is being treated?				_____ _____ _____			
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		Yes	No	DK
Do you wear contact lenses?	☐	☐	☐	Do you use controlled substances (drugs)?	☐	☐	☐

	Yes	No	DK
Are you taking, or have you taken, any diet drugs such as Pondimin (fenflluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?	☐	☐	☐

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ ☐ ☐
If so, how interested are you in stopping?
(Circle one) VERY / SOMEWHAT / NOT INTERESTED

	Yes	No	DK
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐

Do you drink alcoholic beverages? ☐ ☐ ☐
If yes, how much alcohol did you drink in the last 24 hours? _____
If yes, how much do you typically drink In a week? _____

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐ ☐
Date Treatment began: _____

WOMEN ONLY Are you:
	Yes	No	DK
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ ☐ ☐
Date: _____ If yes, have you had any complications? _____

Allergies - Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK		Yes	No	DK
Local anesthetics_____	☐	☐	☐	Metals_____	☐	☐	☐
Aspirin _____	☐	☐	☐	Latex (rubber) _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐	Iodine _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills____	☐	☐	☐	Hay fever/seasonal_____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐	Animals_____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐	Food _____	☐	☐	☐
				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		Yes	No	DK
Heart murmur	☐	☐	☐	Anemia	☐	☐	☐	Chronic pain	☐	☐	☐	Sleep disorder	☐	☐	☐
Mitral valve prolapse	☐	☐	☐	Blood transfusion	☐	☐	☐	Diabetes Type I or II	☐	☐	☐	Mental health disorders	☐	☐	☐
Artificial heart valves	☐	☐	☐	If yes, date:_____				Eating disorder	☐	☐	☐	Specify:_____			
Rheumatic fever	☐	☐	☐	Hemophilia	☐	☐	☐	Malnutrition	☐	☐	☐	Recurrent Infections	☐	☐	☐
				AIDS or HIV infection	☐	☐	☐	Gastrointestinal disease	☐	☐	☐	Type of infection:_____			
Cardiovascular disease.	☐	☐	☐	Arthritis	☐	☐	☐	G.E. Reflux/persistent				Kidney problems	☐	☐	☐
Angina	☐	☐	☐	Autoimmune disease	☐	☐	☐	heartburn	☐	☐	☐	Night sweats	☐	☐	☐
Arteriosclerosis	☐	☐	☐	Rheumatoid arthritis	☐	☐	☐	Ulcers	☐	☐	☐	Osteoporosis	☐	☐	☐
Congestive heart failure	☐	☐	☐	Systemic lupus				Thyroid problems	☐	☐	☐	Persistent swollen glands			
Coronary artery disease	☐	☐	☐	erythematosus	☐	☐	☐	Stroke	☐	☐	☐	in neck	☐	☐	☐
Damaged heart valves	☐	☐	☐	Asthma	☐	☐	☐	Glaucoma	☐	☐	☐	Severe headaches/			
Heart attack	☐	☐	☐	Bronchitis	☐	☐	☐	Hepatitis, jaundice or				migraines	☐	☐	☐
Low blood pressure	☐	☐	☐	Emphysema	☐	☐	☐	liver disease	☐	☐	☐	Severe or rapid weight loss	☐	☐	☐
High blood pressure	☐	☐	☐	Sinus trouble	☐	☐	☐	Epilepsy	☐	☐	☐	Sexually transmitted disease	☐	☐	☐
Congenital heart defects	☐	☐	☐	Tuberculosis	☐	☐	☐	Fainting spells or seizures	☐	☐	☐	Excessive urination	☐	☐	☐
Pacemaker	☐	☐	☐	Cancer/Chemotherapy/				Neurological disorders	☐	☐	☐				
Rheumatic heart disease	☐	☐	☐	Radiation Treatment	☐	☐	☐	If yes, Specify:_____							
Abnormal bleeding	☐	☐	☐	Chest pain upon exertion	☐	☐	☐								

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:_____
_____
_____
_____