**An accurate and complete health history will assist in coordinating your dental care.**

**Please speak with the doctor or staff if there are any questions about this form.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DENTAL HISTORY**

Please describe your current dental health: Excellent Good Fair Poor

Please describe why you are in the office today\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have there been any changes in your dental health in the past year? Yes / No

If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you having any dental discomfort at this time? Yes / No

If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any adverse effects from dental treatment? Yes / No

If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last dental visit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DENTAL HISTORY - Do you have or have you ever had any of the following:**

Bleeding, sore gums? Yes / No Shifting in bite? Yes / No

Unpleasant taste/bad breath? Yes / No Change in bite? Yes / No

Swelling/lumps in mouth? Yes / No Burning tongue/lips? Yes / No

Orthodontic treatment (braces?) Yes / No Frequent blister, lips/mouth? Yes / No

Clenching/grinding? Yes / No Sensitive teeth (hot or cold?) Yes / No

Sensitive to sweets? Yes / No Clicking/popping jaw? Yes / No

Sensitive to biting? Yes / No Difficulty opening or closing jaw? Yes / No

Food Impaction? Yes / No Loose teeth? Yes / No

Biting cheeks/lips? Yes / No

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**MEDICAL HISTORY**

Please describe your current overall health: Excellent Good Fair Poor

Have there been any changes in your general health in the past year? Yes / No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you now under a doctor’s care for a medical condition? Yes / No Date of last physical exam?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized or had a serious illness? Yes / No

If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had surgery? Yes / No

If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**MEDICAL HISTORY (continued) -** Do you have, or have you ever had, any of the following conditions:

|  |  |  |  |
| --- | --- | --- | --- |
| Congenital heart disease, cardiovascular disease – like heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker? | Yes / No | Lung disease – like asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing?  | Yes / No |
| Implants placed anywhere in the body – like heart valve, pacemaker, hip, knee?  | Yes / No | Bleeding disorder, anemia, bleeding tendency, blood transfusion, or bruise easily?  |  Yes / No |
| Kidney disease or kidney failure, requiring dialysis? | Yes / No | Liver disease – like jaundice, hepatitis A, B, or C? | Yes / No |
| Thyroid disease?  | Yes / No | Arthritis?  | Yes / No |
| Stomach ulcers or colitis? | Yes / No | Significant weight loss or gain? | Yes / No |
| Diabetes? | Yes / No | Sinus or nasal problems? | Yes / No |
| Glaucoma? | Yes / No |  Sleep apnea?  | Yes / No |
| Cancer?  If yes, type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Treatments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Yes / No |  Osteoporosis or osteopenia?  | Yes / No   |
| Do you have any other medical conditions that are important for your doctor to know about? Yes / No If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

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| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****FAMILY MEDICAL HISTORY -** Do you have a family history of any of the following conditions?  |
| Diabetes? Yes / No Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_ | Heart disease? Yes / No Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Lung disease? Yes / No Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_ | Bleeding problems? Yes / No Relationship\_\_\_\_\_\_\_\_\_\_\_\_ |
| Cancer? Yes / No Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Has an immediate family member had any problems with local anesthesia, general anesthesia, and/or intravenous sedation? Yes / No  If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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|  **Medications** – Are you currently prescribed or taking any of the following: |
| Antibiotics? | Yes / No | Prescription pain medication? | Yes / No |  |
| Anticoagulants or blood thinners? | Yes / No | Aspirin or drugs such as Motrin, Aleve, Ibuprofen? | Yes / No |  |
| Heart medications? | Yes / No | Insulin or oral anti-diabetic drugs? | Yes / No |  |
| Steroids – like cortisone or prednisone? | Yes / No | Blood pressure medications? | Yes / No |  |
| Antianxiety agents, antidepressants, or other psychiatric medications? | Yes / No | Bisphosphonates or other medications to strengthen your bones?  | Yes / No |  |
|  Cancer or chemotherapy drugs?  | Yes / No | Any other medications or supplements? | Yes / No |  |

**ALLERGIES – Are you allergic to or have you had an adverse reaction to:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Medications (continued):** Please list the specific medications indicated above and/or any other medications not listed above that you are currently taking. Please including all prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins, or minerals:

|  |  |
| --- | --- |
| **Medication and dose** | **Medication and dose** |
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| --- | --- | --- | --- |
| Latex? | Yes / No | Codeine or other pain control medications? | Yes / No |
| Food or food products? | Yes / No | Aspirin, ibuprofen (Motrin), or naproxen (Aleve)? | Yes / No |
| Sedatives or barbiturates? | Yes / No | Penicillin or other antibiotics? | Yes / No |
| Any other medications? | Yes / No |

|  |
| --- |
| Any other allergies? |

 | Yes / No |

If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**ANESTHESIA HISTORY**

Have you had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes / No

If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FEMALE PATIENTS** Are you pregnant? Yes / No Is there any chance you might be pregnant? Yes / No

**SOCIAL HISTORY**

|  |  |  |
| --- | --- | --- |
| Have you ever smoked, vaped or chewed tobacco? | Yes / No | Do you use:  |
|  If yes, for how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  Alcohol? Yes / No If yes, how often per week?\_\_\_\_\_\_ |
| Have you ever sought professional care or been hospitalized for:  |  |  Marijuana? Yes / No If yes, how often per week?\_\_\_\_\_\_ Recreational drugs? Yes / No If yes, how often per week?\_\_\_\_\_\_ |
|  Substance abuse  | Yes / No |   |
|  Emotional disorders | Yes / No |  |
|  Alcoholism | Yes / No |  |

**DO YOU WISH TO TALK TO THE DOCTOR ABOUT ANYTHING IN PRIVATE?** Yes / No

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I understand the importance of a truthful and complete health history to assist my doctor in providing coordinated care.

To the best of my knowledge, the above information is complete and correct.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient, parent, guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of patient, parent, guardian/Relationship

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**For office staff use - HEALTH HISTORY REVIEW**

Date Comments Doctor’s Signature

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**For office staff use - ADDITIONAL CLINICAL DOCUMENTATION**

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