Health History Form

Patient Name: ______________________

Date of Birth: ______________________

Medical History

	Question	Yes	No
1)	In the past 2 years, have you been hospitalized or have you been (or are presently being) treated by a medical doctor or naturopath? If yes, please explain: Doctor: ___________________________City:________________ Phone #:__________________	☐ Yes	☐ No
2)	When was your last complete physical examination?		
3)	List any surgeries you have had (include approximate dates):		
4)	List all PRESCRIPTION or NON-PRESCRIPTION drugs that you are presently taking (or took within the last 2 years) including herbal remedies, supplement and vitamins. (Use the back of this page if more space is needed)		
5)	Have you ever reacted poorly to any medications or injections? **If yes**, please circle: Penicillin, Amoxicillin, Sulfa drugs, other antibiotics, Aspirin, Codeine, Local Anesthetic (Freezing), Nitrous Oxide (laughing gas), Barbiturates (sleeping pills), other medicine: ___________________	☐ Yes	☐ No
6)	Have you ever been advised against taking a medication? If so, please list:	☐ Yes	☐ No
7)	Circle any items that apply to you: Asthma, Hay Fever, Food allergies, Metal Allergy, Latex Allergy, Skin Rashes, Hives, other allergic conditions (list):		
8)	Is there a family history of Diabetes, High Blood Pressure/Heart Disease, or Cancer?	☐ Yes	☐ No
9)	Do you bleed EXCESSIVELY from a cut or injury, or bruise easily?	☐ Yes	☐ No
10)	Do your ankles, feet or hands swell?	☐ Yes	☐ No
11)	Has your weight, appetite or energy level changed **dramatically** recently?	☐ Yes	☐ No
12)	Do you experience shortness of breath or chest pain when walking or climbing stairs?	☐ Yes	☐ No
13)	Do you follow a special diet, or are you on a diet pill therapy?	☐ Yes	☐ No
14)	Have you ever tested positive for an infectious disease (eg. HIV, hepatitis, strep, STD)? If yes, please list and describe treatment received, and pertinent dates:	☐ Yes	☐ No
15)	Have you recently had any of the following (circle those that apply and indicate approximate date): Measles __________ Mumps ___________ Chicken Pox __________ Strep Throat __________ Tonsilitis __________	☐ Yes	☐ No
16)	Do you have FREQUENT SEVERE headaches, earaches, ear/throat infection?	☐ Yes	☐ No
17)	Have you ever had an injury or surgery to your face or jaws?	☐ Yes	☐ No
18)	Do you wear eyeglasses or contact lenses?	☐ Yes	☐ No
19)	Do you have any hearing difficulties? If so, do you wear a hearing aid?	☐ Yes	☐ No
20)	Do you smoke or use any other forms of tobacco (including transdermal nicotine patch)? If yes, how many packs/day and for how many years?	☐ Yes	☐ No
21)	Do you take recreational drugs (eg. marijuana)? NOTE: many drugs interact with local anesthetic, laughing gas, and other medications that your dentist may prescribe and can have serious side effects.	☐ Yes	☐ No
22)	Are you or have you ever been alcohol and/or drug dependent? If yes, please describe:	☐ Yes	☐ No

Patient Name: Date:

23) WOMEN ONLY: Are you pregnant or suspect you may be? If you are pregnant, how many weeks? _______________ If you are not pregnant: Are you taking any birth control? ________ Are you breast feeding?________	☐ Yes	☐ No

24) Read the following list of conditions, and circle any that you have ever had, or presently have:

AIDS	Cortisone/Steroids	High blood pressure	Neuralgia
Alzheimer's	Dementia	High blood sugar	Organ transplant
Anemia	Depression	Hodgkins disease	Osteoarthritis
Angina Pectoris	Diabetes	Hormonal disorders	Pain condition
Anorexia	Dry mouth (chronic)	Hyperglycemia	Parkinson's
Anxiety	Eating disorder	Hypertension	Radiation treatment
Arthritis	Emphysema	Hypoglycemia	Reflux disease
Artificial heart valve	Epilepsy/seizures	Hypotension	Rheumatism
Artificial joints (hip, knee…)	Fainting or dizzy spells	Immune system problems	Rheumatoid Arthritis
Asthma	Fibromyalgia	Intestinal problems	Rheumatic fever
Autoimmune condition	Fungal infection	Jaundice	Scarlet fever
Bone disease	Glandular disorders	Kidney disease	Sickle cell disease
Blood disorders	Glaucoma	Low blood pressure	Sinus trouble
Brain injury/disorder	GERD	Low blood sugar	Sjogren's
Bronchitis	HIV	Liver disease	Strep
Bulimia	Head/neck injuries	Lung disease	Skin conditions
Cancer	Heart disease	Lupus	STDs
Candidiasis	Heart attack	Malignant hyperthermia	Stomach problems
Cardiovascular disease	Heart murmur	Mental disorder	Stroke
Chemotherapy	Heart pacemaker	Mitral valve prolapse	Thrush
Circulation problems	Heart rhythm problems	Multiple Sclerosis	Thyroid disease
COPD	Heart surgery	Muscle disease	Tuberculosis
Cold sores	Hepatitis (A, B, C)	Musculoskeletal disorder	Ulcers
Congenital heart lesions	Herpes	Nerve problems (eg. MS)	Venereal disease
			Other: ___________

25) Is there anything else about your health we should be made aware of? If yes, please describe:	☐ Yes	☐ No
26) Do you wish to speak to the dentist privately about any problem or medical condition?	☐ Yes	☐ No

Dental History

1) Is there a dental problem you would like treated first? If yes, please describe: If not, what is the reason for your visit today?	☐ Yes	☐ No
2) Have you been seeing a dentist regularly? Date of last dental visit: _________________ Date of last cleaning: _________________ Date of last x-rays: _______________	☐ Yes	☐ No
3) Have you ever had any of the following treatment? Circle the ones that apply: Periodontal (gum surgery) Orthodontic (straighten teeth) Bite plate/night guard An appliance Root canal Bite adjusted (teeth ground down) Oral surgery (teeth pulled, wisdom teeth, jaw/joint surgery, implants) Biopsy	☐ Yes	☐ No

4)	Are there any growths or sore spots in your mouth?	☐ Yes	☐ No
5)	Do your gums bleed when brushing or eating, or do you suffer from pain or swelling of your gums?	☐ Yes	☐ No
6)	Have you noticed any loose teeth, or have any of your teeth shifted?	☐ Yes	☐ No
7)	Does food catch between your teeth?	☐ Yes	☐ No
8)	Are any of your teeth sensitive to heat, cold, sweets or pressure?	☐ Yes	☐ No
9)	Have you been advised to take antibiotics before a dental appointment?	☐ Yes	☐ No
10)	Do you use dental floss, proxabrush or stimudents? How often?	☐ Yes	☐ No
11)	Circle the kind of toothbrush that you use: Electric brush Battery-operated spin brush Manual brush: hard bristles medium bristle soft bristles ultra-soft bristles		
12)	How many times a day do you brush your teeth? _________ Morning or night? _________________		
13)	Do you feel that you brush hard ? (and have you been told that you brush hard now or in the past)	☐ Yes	☐ No
14)	Do you feel that you have bad breath?	☐ Yes	☐ No
15)	Have you ever experienced any of the following jaw problems? Circle the ones that apply: Popping Clicking Grating sounds Pain when clenching Pain when chewing Jaw locked open Jaw locked closed Pain around ear Pain in joint Difficulty opening mouth Difficulty closing mouth	☐ Yes	☐ No
16)	Do you have any of the following habits? Circle the ones that apply: Clenching Grinding Cheek biting Lip biting Chewing nails/cuticles Thumb/finger sucking Mouth breathing Holding a foreign object between your teeth (eg. pencil, sewing needle, nails, pipe) Opening or tearing items with your teeth; if yes, describe: ____	☐ Yes	☐ No
17)	Do you have any emotional concerns about having dental treatment?	☐ Yes	☐ No
18)	Are you unhappy with the appearance of your teeth? If so, what would you like to see changed?	☐ Yes	☐ No
19)	Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment? If yes, please describe:	☐ Yes	☐ No
20)	Do you have any questions for the dentist? If yes, please describe:	☐ Yes	☐ No

I, the undersigned, certify that I have provided an accurate health history to the best of my knowledge, and have not knowingly omitted any information. I have had the opportunity to ask questions regarding my health history. Should there be any change in either my health status or any other information I have provided, I will advise this dental office. Failure to do so may negatively affect my health and/or dental treatment outcome.

_______________________________________   __________________________

Name of Patient   Date

_______________________________________   _______________________________________

Signature of Patient
(or Parent/Legal Guardian/Power of Attorney)

Name of Parent/Legal Guardian/Power of Attorney
(if applicable)

Reviewed by treating dentist:

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Date:

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