Health History Form

Date _____

Patient Name _____ Dr. _____

Occupation _____ Height _____ Weight _____

Date of Birth_____/_____/_____ Sex: ❑ M ❑ F

Emergency Contact _____ Relationship _____ Phone ( ) _____

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

Name _____ Relationship _____

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your Initial visit 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

Yes	No	Don't Know	
❑	❑	❑	Do you feel you may have bad breath at times?
❑	❑	❑	Do your gums bleed when you brush?
❑	❑	❑	Are your teeth sensitive to cold, hot, sweets or pressure?
❑	❑	❑	Have you had periodontal (gum) treatments?
❑	❑	❑	Do you occasionally have, an unpleasant taste in your mouth?
❑	❑	❑	Have you ever had orthodontic (braces) treatment?
❑	❑	❑	Do you have headaches, earaches or neck pains?
❑	❑	❑	Do you wear removable dental appliances?
❑	❑	❑	Have you had a serious/difficult problem associated with any previous dental treatment? If so, explain:

_____

How would you describe you current dental problem?

_____

_____

_____

Date of your last dental exam _____ Date of last dental x-rays _____

What was done at that time?

_____

_____

_____

How do you feel about the appearance of your teeth?

_____

_____

_____

Medical Information

Yes No Don't Know

❑ ❑ ❑ Are you in good health?

❑ ❑ ❑ Have there been any changes in your general health within the past year? If so, explain:

_____

Do you have any of the following diseases or problems:

❑ ❑ ❑ Active Tuberculosis

❑ ❑ ❑ Persistent cough greater than a 3 week duration

❑ ❑ ❑ Cough that produces blood,

❑ ❑ ❑ Are you now under the care of a physician? If so, what is/are the condition(s) being treated?

_____ Date of last physical examination _____

Physician(s) _____

NAME PHONE ADDRESS CITY/STATE/ZIP

_____

NAME PHONE ADDRESS CITY/STATE/ZIP

❑ ❑ ❑ Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, what was the illness or problem? _____

❑ ❑ ❑ Are you taking or have you recently taken any medicine(s) including non-prescription medicine? If so, what medicine(s) are you taking?

Prescribed _____

Over the counter _____

Natural or herbal preparations _____

❑ ❑ ❑ Are you taking, or have you taken, any diet drugs such as Pondimin (fendluramine), Redux (desphenfluramine) or phen-fen (phentermine)? _____

❑ ❑ ❑ Are you alcohol and/or drug dependent? If so, have you received treatment? (Check one) ❑Yes ❑ No

❑ ❑ ❑ Do you use drugs or other substances or recreational purposes? If yes, please list

_____

Frequency of use (daily, weekly, etc.) _____ Number of years of recreational drug use _____

❑ ❑ ❑ Do you Use tobacco (smoking, snuff, chew)? If so how interested are you in stopping?

(Check one) ❑Very ❑ Somewhat ❑ Not interested

❑ ❑ ❑ Do you wear contact lenses?

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

Yes No Don't Know

❑ ❑ ❑ Local anesthetics

❑ ❑ ❑ Aspirin

❑ ❑ ❑ Penicillin or other antibiotics

❑ ❑ ❑ Barbiturates, sedatives, or sleeping pills

❑ ❑ ❑ Sulfa drugs

❑ ❑ ❑ Codeine or other narcotics

❑ ❑ ❑ Latex

❑ ❑ ❑ Iodine

❑ ❑ ❑ Hay fever/seasonal

❑ ❑ ❑ Animals

❑ ❑ ❑ Food (specify)

❑ ❑ ❑ Other Specify)

To yes responses, specify type of reaction

_____

_____

_____

Patient Name _____

Dr. _____

Yes	No	Don't Know	
❑	❑	❑	Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If so when was this operation done? _____
❑	❑	❑	Have you had any complications or difficulties with your prosthetic joint?
❑	❑	❑	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? If so, what antibiotic and dose? _____
			Name of physician or dentist _____ Phone _____

Please (X) if you have or had any of the following diseases or problems:

Yes	No	Don't Know	
❑	❑	❑	Abnormal bleeding
❑	❑	❑	AIDS or HIV infection
❑	❑	❑	Anemia
❑	❑	❑	Arthritis
❑	❑	❑	Rheumatoid arthritis
❑	❑	❑	Asthma
❑	❑	❑	Blood transfusion If yes, date _____
❑	❑	❑	Cardiovascular disease If yes, specify below
			❑ Angina
			❑ Arteriosclerosis
			❑ Artificial heart valves
			❑ Coronary insufficiency
			❑ Coronary occlusion
			❑ Damaged heart valves
			❑ Heart attack
			❑ Heart murmur
			❑ High blood pressure
			❑ Inborn heart defects
			❑ Mitral valve prolapse
			❑ Pacemaker
			❑ Rheumatic heart disease
			❑ Chest pain upon exertion
			❑ Chronic pain
			❑ Persistent diarrhea
❑	❑	❑	Disease, drug or radiation induced immunosuppression
			Diabetes, If yes specify below:.
			❑ Type I (insulin dependent)
			❑ Type II
❑	❑	❑	Dry Mouth
❑	❑	❑	Eating disorder. If yes, specify _____
❑	❑	❑	Epilepsy
❑	❑	❑	Fainting spells or seizures
❑	❑	❑	G E. reflux

Yes	No	Don't Know	
❑	❑	❑	Glaucoma
❑	❑	❑	Hemophilia
❑	❑	❑	Hepatitis, jaundice or liver disease
❑	❑	❑	Recurrent infections, Indicate type of infection_____
❑	❑	❑	Kidney problems
❑	❑	❑	Low blood pressure
❑	❑	❑	Mental health disorders. If yes, specify _____ _____
❑	❑	❑	Malnutrition
❑	❑	❑	Migraines
❑	❑	❑	Night sweats
❑	❑	❑	Neurological disorders If yes, specify _____ _____
❑	❑	❑	Osteoporosis
❑	❑	❑	Persistent swollen glands in neck
❑	❑	❑	Respiratory problems If yes, specify below
			❑ Emphysema
			❑ Bronchitis, etc.
❑	❑	❑	Severe headaches
❑	❑	❑	Severe or rapid weight loss
❑	❑	❑	Sexually transmitted disease
❑	❑	❑	Sinus trouble
❑	❑	❑	Sleep disorder
❑	❑	❑	Sores or ulcers in the mouth
❑	❑	❑	Stroke
❑	❑	❑	Systemic lupus erythernatosus
❑	❑	❑	Thyroid problems
❑	❑	❑	Tuberculosis
❑	❑	❑	Ulcers
❑	❑	❑	Excessive urination
❑	❑	❑	Do you have any disease, condition, or problem not listed above that you think I should know about? Please explain: _____ _____ _____ _____

(Women Only)

Yes	No	Don't Know	
❑	❑	❑	Are you pregnant?
❑	❑	❑	Nursing?
❑	❑	❑	Taking birth control pills?

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. 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 Dr. Zuerlein

Comments on patient interview concerning health history

Significant findings from questionnaire or oral interview

Dental management considerations

Signature of Dentist _____ Date _____