

# HEALTH HISTORY FORM

Patient's Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Gender \_\_\_\_\_

Height \_\_\_\_\_

Weight \_\_\_\_\_

Today's Date \_\_\_\_\_

**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		

## 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?	Yes / No	Osteoporosis or osteopenia?	Yes / No

If yes, type \_\_\_\_\_

Diagnosis date \_\_\_\_\_

Treatments \_\_\_\_\_

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 \_\_\_\_\_

## 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

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**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

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

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 \_\_\_\_\_

## 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

If yes, for how long? \_\_\_\_\_

**Have you ever sought professional care or been hospitalized for:**

Substance abuse Yes / No

Emotional disorders Yes / No

Alcoholism Yes / No

**Do you use:**

Alcohol? Yes / No If yes, how often per week? \_\_\_\_\_

Marijuana? Yes / No If yes, how often per week? \_\_\_\_\_

Recreational drugs? Yes / No If yes, how often per week? \_\_\_\_\_

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

**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

