ADA. American Dental Association
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Medical Alert:	Condition:	Premedication:	Allergies:	Anesthesia:	Date:

HEALTH HISTORY FORM

Name: _____ Home Phone: ( ) _____ *Business Phone:* ( ) _____
LAST FIRST MIDDLE

Address: _____ City: _____ State: _____ Zip Code: _____
P.O. BOX or Mailing Address

Occupation: _____ Height: _____ Weight: _____ Date of Birth: _____ Sex: M ❑ F ❑

SS#: _____ 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 your gums bleed when you brush?	❑	❑	❑
Have you ever had orthodontic (braces) treatment?	❑	❑	❑
Are your teeth sensitive to cold, hot, sweets or pressure?	❑	❑	❑
Do you have earaches or neck pains?	❑	❑	❑
Have you had any periodontal (gum) treatments?	❑	❑	❑
Do you wear removable dental appliances?	❑	❑	❑
Have you had a serious/difficult problem associated with any previous dental treatment?	❑	❑	❑

If yes, explain: _____

How would you describe your 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
If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.			
Have you had any of the following diseases or problems?			
Active Tuberculosis	❑	❑	❑
Persistent cough greater than a 3 week duration	❑	❑	❑
Cough that produces blood	❑	❑	❑
Are you in good health?	❑	❑	❑
Has there been any change in your general health within the past year?	❑	❑	❑
Are you now under the care of a physician?	❑	❑	❑

If yes, what is/are the condition(s) being treated? _____

Date of last physical examination: _____

Physician: _____
NAME PHONE

ADDRESS CITY/STATE ZIP

NAME PHONE

ADDRESS CITY/STATE ZIP

	Yes	No	Don't Know
Have you had any serious illness, operation, or been hospitalized in the past 5 years?	❑	❑	❑

If yes, what was the illness or problem? _____

	Yes	No	Don't Know
Are you taking or have you recently taken any medicine(s) including non-prescription medicine?	❑	❑	❑

If yes, what medicine(s) are you taking?

Prescribed: _____

Over the counter: _____

Vitamins, natural or herbal preparations and/or diet supplements: _____

	Yes	No	Don't Know
Are you taking, or have you taken, any diet drugs such Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?	❑	❑	❑
Do you drink alcoholic beverages?	❑	❑	❑

If yes, how much alcohol did you drink in the last 24 hours? _____

In the past week? _____

	Yes	No	Don't Know
Are you alcohol and/or drug dependent?	❑	❑	❑

If yes, have you received treatment? (circle one) Yes / No

	Yes	No	Don't Know
Do you use drugs or other substances for recreational purposes?	❑	❑	❑

If yes, please list: _____

Frequency of use (daily, weekly, etc.): _____

Number of years of recreational drug use: _____

	Yes	No	Don't Know
Do you use tobacco (smoking, snuff, chew)?	❑	❑	❑

If yes, how interested are you in stopping?
(circle one) Very / Somewhat / Not interested

	Yes	No	Don't Know
Do you wear contact lenses?	❑	❑	❑

PLEASE COMPLETE BOTH SIDES

	Yes	No	Don't Know
Are you allergic to or have you had a reaction to?			
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) _____	☐	☐	☐
Metals (specify) _____	☐	☐	☐

To yes responses, specify type of reaction. _____

	Yes	No	Don't Know
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
If yes, when was this operation done? _____			
If you answered yes to the above question, 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 yes, what antibiotic and dose? _____			
Name of physician or dentist*: _____			
Phone: _____			

WOMEN ONLY

	Yes	No	Don't Know
Are you or could you be pregnant?	☐	☐	☐
Nursing?	☐	☐	☐
Taking birth control pills or hormonal replacement?	☐	☐	☐

Please (X) a response to indicate if you have or have not 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: _____	☐	☐	☐
Cancer/Chemotherapy/Radiation Treatment	☐	☐	☐
Cardiovascular disease. If yes, specify below:	☐	☐	☐
____ Angina ____ Heart murmur			
____ Arteriosclerosis ____ High blood pressure			
____ Artificial heart valves ____ Low blood pressure			
____ Congenital heart defects ____ Mitral valve prolapse			
____ Congestive heart failure ____ Pacemaker			
____ Coronary artery disease ____ Rheumatic heart			
____ Damaged heart valves disease/Rheumatic fever			
____ Heart attack			
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Disease, drug, or radiation-induced immunosurpression	☐	☐	☐
Diabetes. If yes, specify below:	☐	☐	☐
____ Type I (Insulin dependent) ____ Type II			
Dry Mouth	☐	☐	☐
Eating disorder. If yes, specify: _____	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Glaucoma	☐	☐	☐

	Yes	No	Don't Know
Hemophilia	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Recurrent Infections	☐	☐	☐
If yes, indicate type of infection: _____			
Kidney problems	☐	☐	☐
Mental health disorders. If yes, specify: _____	☐	☐	☐
Malnutrition	☐	☐	☐
Night sweats	☐	☐	☐
Neurological disorders. If yes, specify: _____	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck			
Respiratory problems. If yes, specify below:	☐	☐	☐
____ Emphysema ____ Bronchitis, etc.			
Severe headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Sinus trouble	☐	☐	☐
Sleep disorder	☐	☐	☐
Sores or ulcers in the mouth	☐	☐	☐
Stroke	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Tuberculosis	☐	☐	☐
Thyroid problems	☐	☐	☐
Ulcers	☐	☐	☐
Excessive urination	☐	☐	☐
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. 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 on patient interview concerning health history: _____

Significant findings from questionnaire or oral interview: _____

Dental management considerations: _____

Health History Update: On a regular basis the patient should be questioned about any medical history changes, date and comments notated, along with signature.

Date	Comments	Signature of patient and dentist