



# Patient Health History Form

Name: \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First Middle Name  
 Date of birth: \_\_\_\_\_ Sex: M  F  Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 If you are completing this form for another person, what is your name and relationship to that person? \_\_\_\_\_  
 Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, can have an important interrelationship with your oral health and the dentistry you will receive. Thank you for answering the following questions. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that 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.  
 How were you referred to our office? \_\_\_\_\_

## Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Are you now under the care of a physician? YES  NO   
 Physician Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
 Address/City/State/Zip \_\_\_\_\_  
 Are you in good health? .....YES  NO   
 Has there been any change in your general health within the past year? .....YES  NO   
 If yes, what condition is being treated? \_\_\_\_\_  
 Date of last physical exam: \_\_\_\_\_  
 Have you had a serious illness, operation or been hospitalized in the past 5 years? .....YES  NO   
 If yes, what was the illness or problem? \_\_\_\_\_

### PRE-MEDICATION - Antibiotic pre-medication may be required prior to dental treatment for the following conditions only

Joint Replacement – Orthopedic total joint (hip, knee, elbow, finger) within the last 2 years ..... YES  NO   
 Any form of vascular stints ..... YES  NO   
 Artificial (prosthetic) heart valve ..... YES  NO   
 Previous infective endocarditis ..... YES  NO   
 Damaged valves in transplanted heart ..... YES  NO   
 Congenital heart disease (CHD) ..... YES  NO   
     Unrepaired, cyanotic CHD ..... YES  NO   
     Repaired (completely) in last 6 months ..... YES  NO   
     Repaired CHD with residual defects ..... YES  NO   
 Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? YES  NO  If so why?  
 Name of physician or dentist making recommendation: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? YES  NO   
 Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ..... YES  NO   
 Date Treatment began: \_\_\_\_\_

### Allergies - Are you allergic to or have you had a reaction to: To all yes responses specify type of reaction.

Local anesthetic ..... YES <input type="checkbox"/> NO <input type="checkbox"/>	Latex (rubber) ..... YES <input type="checkbox"/> NO <input type="checkbox"/>
Aspirin ..... YES <input type="checkbox"/> NO <input type="checkbox"/>	Iodine ..... YES <input type="checkbox"/> NO <input type="checkbox"/>
Penicillin or other antibiotics ..... YES <input type="checkbox"/> NO <input type="checkbox"/>	Hay fever/seasonal ..... YES <input type="checkbox"/> NO <input type="checkbox"/>
Barbiturates, sedatives, sleeping pills ..... YES <input type="checkbox"/> NO <input type="checkbox"/>	Animals ..... YES <input type="checkbox"/> NO <input type="checkbox"/>
Sulfa drugs ..... YES <input type="checkbox"/> NO <input type="checkbox"/>	Food ..... YES <input type="checkbox"/> NO <input type="checkbox"/>
Codeine or other narcotics ..... YES <input type="checkbox"/> NO <input type="checkbox"/>	Other ..... YES <input type="checkbox"/> NO <input type="checkbox"/>
Metals ..... YES <input type="checkbox"/> NO <input type="checkbox"/>	





## Patient Dental

## Information

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Last First Middle initial  
 Are you currently experiencing any dental discomfort/problem? YES  NO  If yes, explain: \_\_\_\_\_  
 Are you interested on a comprehensive dental life plan evaluation or on basic dental care maintenance? \_\_\_\_\_  
 Name of last Dentist: \_\_\_\_\_ City/ State \_\_\_\_\_  
 Date of your last dental visit: \_\_\_\_\_ what was done at that time? \_\_\_\_\_  
 When was your last dental cleaning? \_\_\_\_\_ Date of last dental x-rays: \_\_\_\_\_

### Dental History Please mark (X) your response

How often do you brush? \_\_\_\_\_ What kind of toothbrush do you use? Manual  Electric  Battery  What brand is it: \_\_\_\_\_  
 Do you floss your teeth? YES  NO  If yes how often? Occasionally  Daily  A few days a week  A few days a month  I do not floss   
 Do you use mouthwash? YES  NO  what brand/kind? \_\_\_\_\_  
 Do you drink bottled or filtered water? YES  NO  If yes, how often? DAILY  WEEKLY  OCCASIONALLY   
 Is your home water supply fluoridated? YES  NO  DON'T KNOW   
 Have you had any periodontal (gum) treatments? YES  NO  Explain what and when: \_\_\_\_\_  
 Have you ever had orthodontic (braces) treatment? YES  NO  When? : \_\_\_\_\_ Orthodontist Name: \_\_\_\_\_  
 Have you had any problems associated with previous dental treatment YES  NO  If yes explain: \_\_\_\_\_  
 Do you wear dentures or partials? YES  NO  **Would you be interested or contemplating dental implant(s)?** YES  NO   
 Have you ever had a serious injury to your head or mouth? YES  NO  If yes explain: \_\_\_\_\_

### Do you experience any of the following problems or symptoms?

Teeth sensitive to hot .....	YES <input type="checkbox"/> NO <input type="checkbox"/>	Blister on lips and mouth .....	YES <input type="checkbox"/> NO <input type="checkbox"/>
Teeth sensitive to cold .....	YES <input type="checkbox"/> NO <input type="checkbox"/>	Lip or check biting .....	YES <input type="checkbox"/> NO <input type="checkbox"/>
Teeth sensitive to sweets .....	YES <input type="checkbox"/> NO <input type="checkbox"/>	Loose teeth or broken filling .....	YES <input type="checkbox"/> NO <input type="checkbox"/>
Teeth sensitive to pressure .....	YES <input type="checkbox"/> NO <input type="checkbox"/>	Chew on one side of the mouth .....	YES <input type="checkbox"/> NO <input type="checkbox"/>
Bleeding gums .....	YES <input type="checkbox"/> NO <input type="checkbox"/>	Food or floss catches between teeth .....	YES <input type="checkbox"/> NO <input type="checkbox"/>
Mouth breathing .....	YES <input type="checkbox"/> NO <input type="checkbox"/>	Pain around the ear or neck .....	YES <input type="checkbox"/> NO <input type="checkbox"/>
Dry mouth .....	YES <input type="checkbox"/> NO <input type="checkbox"/>	Clench or grind teeth.....	YES <input type="checkbox"/> NO <input type="checkbox"/>
Burning sensation on the tongue .....	YES <input type="checkbox"/> NO <input type="checkbox"/>	Jaw pain or tiredness .....	YES <input type="checkbox"/> NO <input type="checkbox"/>
Tender or swollen gums .....	YES <input type="checkbox"/> NO <input type="checkbox"/>	Clicking, popping or discomfort in the jaw .....	YES <input type="checkbox"/> NO <input type="checkbox"/>
Halitosis/ Bad breath .....	YES <input type="checkbox"/> NO <input type="checkbox"/>	How often? _____	
Mouth ulcers .....	YES <input type="checkbox"/> NO <input type="checkbox"/>		

### Esthetic Evaluation

How happy are you with the overall appearance of your teeth and smile? Not happy  Happy  If not explain why: \_\_\_\_\_

