ADA. American Dental Association
www.ada.org

Visit Date	Condition	Participation	Surgery	Anesthetic	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

Are you allergic to or have you had a reaction to?	Yes	No	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) _____	☐	☐	☐
Metals (specify) _____	☐	☐	☐

To yes responses, specify type of reaction.

	Yes	No	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?

	Yes	No	Know
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	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
___ Arteriosclerosis
___ Artificial heart valves
___ Congenital heart defects
___ Congestive heart failure
___ Coronary artery disease
___ Damaged heart valves
___ Heart attack
___ Heart murmur
___ High blood pressure
___ Low blood pressure
___ Mitral valve prolapse
___ Pacemaker
___ Rheumatic heart disease/Rheumatic fever

Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
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	☐	☐	☐
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

HIPPA Privacy Authorization Form

1. I authorize Alan Barr DDS and Staff to use and disclose my protected health information with specialists and, if applicable, my dental insurance, for all past, present and future periods while under the care of Alan Barr DDS.
2. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
3. This medical information may be used by the person(s) I authorize, for dental treatment or consultation, billing or claims payment, or purposes I may direct.
4. This authorization shall be in force and effect until I terminate my relationship with the office of Alan Barr DDS, at which time the authorization expires.
5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition insurance coverage and the insurer has a legal right to contest a claim.
6. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
7. I understand that the information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____

Print name of patient

_____

Signature of patient or personal representative

_____

Date

Sleep Screening Questionnaire

Please answer the questions below to help us assess the possibility of a sleep disorder which may be related to your dental and overall health. There is often a correlation between grinding of the teeth, TMJ disorders, breakdown of the teeth and sleep disorders. Sleep apnea may also increase your risk for many different health conditions including heart attack and stroke. If you are here with your child (under 16), please fill out the lower portion marked "For children only" for your child.

Name:_____ **Height:**_____ **Weight:**_____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

0 = I would never doze
1 = I have a slight chance of dozing
2 = I have a moderate chance of dozing
3 = I have a high chance of dozing

Situation	**Chance of Dozing**
1. Sitting and reading	____
2. Watching TV	____
3. Sitting inactive in a public place (e.g. a theater or a meeting)	____
4. As a passenger in a car for an hour without a break	____
5. Lying down to rest in the afternoon when circumstances permit	____
6. Sitting and talking to someone	____
7. Sitting quietly after lunch without alcohol	____
8. In a car while stopped for a few minutes in traffic	____
Total Score	____

Have you ever been diagnosed with:	**Yes**	**No**
1. Impaired Cognition (i.e. difficulty concentrating or thinking)	☐	☐
2. Mood Disorders/Depression	☐	☐
3. Insomnia	☐	☐
4. Hypertension (high blood pressure)	☐	☐
5. Ischemic Heart Disease (Coronary Artery Disease/Atherosclerosis)	☐	☐
6. History of Stroke	☐	☐
7. Sleep Apnea	☐	☐
If yes: Did you try to use CPAP	☐	☐
8. TMJ problems significant enough to require treatment	☐	☐
9. Gastric Reflux (GERD) or Heartburn	☐	☐

Are you aware of (or have you been told):	**Yes**	**No**
1. Snoring on a regular basis	☐	☐
2. Feeling tired or fatigued on a regular basis	☐	☐
3. Clenching or grinding your teeth (bruxism)	☐	☐
4. Having frequent headaches	☐	☐
5. Your neck size being > 17 inches (male) or > 16 inches (female)	☐	☐
6. Anyone in your family having sleep apnea	☐	☐
7. Stopping breathing when sleeping/awakening with a gasp	☐	☐

For children only (filled out by parent or guardian)

Are you aware of your child:	**Yes**	**No**
1. Snoring/noisy breathing while sleeping	☐	☐
2. Grinding his or her teeth	☐	☐
3. Wetting the bed	☐	☐
4. Having difficulty in school/learning	☐	☐
5. Being treated for ADD or ADHD	☐	☐
6. Breathing primarily through their mouth	☐	☐
7. Having frequent nightmares/night terrors	☐	☐
8. Having frequent ear aches	☐	☐

Dental Exam Findings:
☐ Evidence of Bruxism ☐ Scalloping of the tongue ☐ Crowded airway
☐ Tori or Bone Loss ☐ Anterior wear ☐ Retrognathia / Class II