Health History Form

Uxbridge Dental Center

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. 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.

Name: Home Phone: Cell Phone:

Address: City: State: Zip:

SS# Date of Birth: Sex: M F

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

Do you have any of the following diseases or problems:

	Yes	No
Active Tuberculosis	☐	☐
Persistent cough greater than a 3 week duration	☐	☐
Cough that produces blood	☐	☐

If you answer yes to any of the 3 items above, please stop and return this form to the receptionist.

Dental Information

For the following questions, please mark (X) your responses to the following questions.

	Yes	No
Do your gums bleed when you brush or floss?	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐
Is your mouth dry?	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐
Have you had any problems with previous dental treatment?	☐	☐
Are you currently experiencing dental pain or discomfort?	☐	☐

Date of your last dental exam:

Date of last dental x-rays:

	Yes	No
Do you have any clicking, popping or discomfort in the jaw?	☐	☐
Do you brux or grind your teeth?	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐
Do you wear dentures or partials?	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information

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

	Yes	No
Are you now under the care of a physician?	☐	☐

Physician Name: Phone:

Address/City/State/Zip:

	Yes	No
Are you in good health?	☐	☐

If no, what condition is being treated?

Date of last physical exam:

	Yes	No
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

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Form S500

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

Joint Replacement. Have you had an orthopedic total joint replacement? ☐ Yes ☐ No

Date: ______________ If yes, have you had any complications?

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ Yes ☐ No

If so, how interested are you in stopping?
Circle one: VERY / SOMEWHAT / NOT INTERESTED

WOMEN ONLY Are you:

Pregnant? ☐ ☐ ☐
Number of weeks: ________________

Allergies. Are you allergic to any of the following:

	Yes	No
Local anesthetics	☐	☐
Aspirin	☐	☐
Penicillin or other antibiotics	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Sulfa drugs	☐	☐
Codeine or other narcotics	☐	☐

Other:____
____
____

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

	Yes	No
Artificial (prosthetic) heart valve	☐	☐
Previous infective endocarditis	☐	☐
Congenital heart disease (CHD)	☐	☐

	Yes	No
Tuberculosis	☐	☐
Diabetes Type I or II	☐	☐
Thyroid problems	☐	☐
Sinus trouble	☐	☐
Emphysema	☐	☐
Cancer/Chemotherapy/	☐	☐
Radiation Treatment	☐	☐

	Yes	No
Low blood pressure	☐	☐
High blood pressure	☐	☐
Gastrointestinal disease	☐	☐
Stroke	☐	☐
Heart attack	☐	☐
Autoimmune disease	☐	☐
Kidney problems	☐	☐
Pacemaker	☐	☐
Neurological disorders	☐	☐

If yes, specify:________________________________

	Yes	No
Mitral valve prolapse	☐	☐
Cardiovascular disease	☐	☐
Anemia	☐	☐
Hemophilia	☐	☐
AIDS or HIV infection	☐	☐
Arthritis	☐	☐
Rheumatoid arthritis	☐	☐
Asthma	☐	☐

	Yes	No
Hepatitis, jaundice or liver disease	☐	☐
Epilepsy	☐	☐
Severe headaches/	☐	☐
Sexually transmitted disease	☐	☐
Do you snore?	☐	☐
Sleep disorder	☐	☐
Mental health disorders	☐	☐

Specify: ________________________

Has a physician or previous dentist recommended that you take antibiotics prior to your dental visit? ☐ ☐ ☐

Name of physician or dentist making recommendation: Phone:

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 and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. 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:
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