# HEALTH HISTORY FORM

NAME: _____

## MEDICAL INFORMATION

| | YES | NO |
|---|---|---|
| Are you under a physicians care now? | ☐ | ☐ |
| If yes – Physician Name: _____ | | |
| Have you ever been hospitalized or had a major operation? | ☐ | ☐ |
| If yes – Explain: _____ | | |
| _____ | | |
| Have you ever had a serious head or neck injury? | ☐ | ☐ |
| Do you use tobacco? | ☐ | ☐ |
| How many packs/cigarettes per day? _____ | | |

**ALLERGIES:** Are you allergic to any of the following? MARK IF YES

Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐

Metal ☐ Latex ☐ Local Anesthetics ☐

OTHER: _____

| **WOMEN ONLY:** | YES | NO |
|---|---|---|
| Are you pregnant or trying to get pregnant? | ☐ | ☐ |
| If yes – How many weeks? _____ | | |
| Are you nursing? | ☐ | ☐ |
| Are you taking oral contraceptives? | ☐ | ☐ |

List all current medications, supplements, or controlled substances you are using: _____

_____

_____

## Do you have, or have you had, any of the following diseases or problems? Check if YES

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | ☐ | Chemotherapy | ☐ | Frequent Diarrhea | ☐ | Kidney Problems | ☐ | Stroke | ☐ |
| Anemia | ☐ | Chest Pains | ☐ | Frequent Headaches | ☐ | Liver Disease | ☐ | Thyroid Disease | ☐ |
| Angina | ☐ | Congenital Heart Disorder | ☐ | Genital Herpes | ☐ | Low Blood Pressure | ☐ | Tuberculosis | ☐ |
| Arthritis/Gout | ☐ | Convulsions | ☐ | Glaucoma | ☐ | Lung Disease | ☐ | Tumors or Growths | ☐ |
| Artificial Heart Valve | ☐ | Diabetes | ☐ | Heart Attack/Failure | ☐ | Mitral Valve Prolapse | ☐ | Ulcers | ☐ |
| Artificial Joint | ☐ | Drug Addiction | ☐ | Heart Murmur | ☐ | Psychiatric Care | ☐ | Yellow Jaundice | ☐ |
| Asthma | ☐ | Emphysema | ☐ | Heart Pace Maker | ☐ | Radiation Treatments | ☐ | | |
| Blood Disease | ☐ | Epilepsy of Seizures | ☐ | Heart Trouble/Disease | ☐ | Rheumatic Fever | ☐ | Other: _____ | |
| Blood Transfusion | ☐ | Excessive Bleeding | ☐ | Hepatitis A, B or C | ☐ | Rheumatism | ☐ | _____ | |
| Breathing Problem | ☐ | Fainting Spells/Dizziness | ☐ | High Blood Pressure | ☐ | Sinus Trouble | ☐ | _____ | |
| Cancer | ☐ | Frequent Cough | ☐ | Irregular Heartbeat | ☐ | Stomach Disease | ☐ | _____ | |

## DENTAL INFORMATION

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

| | YES | NO |
|---|---|---|
| Do you have or have had Apthous Ulcers (Canker Sores)? | ☐ | ☐ |
| Do you have or have had Herpes infection (Cold Sores)? | ☐ | ☐ |
| Do you have clicking, popping, or discomfort in the jaw? | ☐ | ☐ |
| Do you grind your teeth? | ☐ | ☐ |
| Do you have sores or ulcers in your mouth? | ☐ | ☐ |
| Do you wear dentures or partials? | ☐ | ☐ |
| Date of last dental exam/x-rays: _____ | | |

**FOR COMPLETION BY DENTIST**

Comments: _____

_____

**Both doctor and patient are encouraged to discuss and all patient health issues or treatment.**

I certify that I 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 inquires 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 because of errors or omissions that may have made in the completion of this form.

**Signature of Patient/Legal Guardian:** **Date:**

**Signature of Doctor:** **Date:**

**MEDICAL UPDATE**

**1. Patient's Signature:** _____ **Doctor's Signature:** _____ **Date:** _____

**2. Patient's Signature:** _____ **Doctor's Signature:** _____ **Date:** _____

**3. Patient's Signature:** _____ **Doctor's Signature:** _____ **Date:** _____