

# Health History Form

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: Last First Middle	Home Phone: <i>Include area code</i> ( )	Business/Cell Phone: <i>Include area code</i> ( )
Address: <i>Mailing address</i>	City:	State: Zip:
Occupation:	Height:	Weight: Date of Birth: Sex: M F
SS# or Patient ID:	Emergency Contact:	Relationship: Home Phone: <i>Include area code</i> Cell Phone: <i>Include area code</i> ( ) ( )
If you are completing this form for another person, what is your relationship to that person? <i>Your Name</i> <i>Relationship</i>		
<b>Do you have any of the following diseases or problems:</b>		(Check DK if you Don't Know the answer to the the question) <b>Yes No DK</b>
Active Tuberculosis.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Persistent cough greater than a 3 week duration.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cough that produces blood.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Been exposed to anyone with tuberculosis.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.</b>		

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

Yes No DK	Yes No DK
Do your gums bleed when you brush or floss? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have earaches or neck pains? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your mouth dry? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you brux or grind your teeth? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any periodontal (gum) treatments? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have sores or ulcers in your mouth? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you ever had orthodontic (braces) treatment? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you wear dentures or partials? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any problems associated with previous dental treatment? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you participate in active recreational activities? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your home water supply fluoridated? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you ever had a serious injury to your head or mouth? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you drink bottled or filtered water? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of your last dental exam: What was done at that time?
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY	Date of last dental x-rays:
Are you currently experiencing dental pain or discomfort? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
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 DK	Yes No DK
Are you now under the care of a physician? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Physician Name: Phone: <i>Include area code</i> ( )	If yes, what was the illness or problem?
Address/City/State/Zip:	Are you taking or have you recently taken any prescription or over the counter medicine(s)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are you in good health? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:
Has there been any change in your general health within the past year? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____
If yes, what condition is being treated?	_____
Date of last physical exam:	_____