

Health History Form

Email: _____ Cell: (____) _____ Today's date: _____

The following information is vital to allow us to provide appropriate care for you. Your information will be kept confidential subject to applicable laws.

Last name: _____ First name: _____ MI: _____ Home Phone: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Gender: **M F** SSN: _____ - _____ - _____ Height: _____ Weight: _____
 (Required for insurance claims)

Occupation: _____

If you are completing this form, what is your relationship to that person?

Your name: _____ Relationship _____

Do you have any of the following conditions? (Check DK if you don't know)

| | Y | N | DK |
|---|--------------------------|--------------------------|--------------------------|
| Active Tuberculosis (TB) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent cough (over 3 weeks) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cough that produces blood _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you under a physician's care? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been recently hospitalized? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you use tobacco? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you use controlled substances (please specify)? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you use medicinal or recreational marijuana (please specify)? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you take, or have you taken, oral or IV Biphosphonates like Boniva, Fosamax, Actonel, Reclast, Aredia or any other medication for Osteoporosis or to help increase bone density? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Dental Information

(Check DK if you don't know)

| | Y | N | DK |
|--|--------------------------|--------------------------|--------------------------|
| Do your gums bleed while brushing or flossing? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are your teeth sensitive to hot, cold, sweet, or pressure? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you grind/clench your teeth during the day or night (Please specify?) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any jaw pain? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you experience any clicking or popping of the TMJ? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear a night guard? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear dentures (full or partials)? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Date of last dental visit: _____ Date of last dental X-rays: _____

Are you **allergic** to any medications? Please list: _____

Please list all medications you are **taking** (including supplements): _____

Do you have or have you had any of the following?

| | Y | N | | Y | N | | Y | N | | Y | N |
|------------------------|---|---|-----------------------------------|---|---|--------------------|---|---|-----------------------|---|---|
| Cardiovascular Disease | | | Hemophilia | | | GI Disease | | | Convulsions | | |
| Heart Attack | | | Bld. Transfusion | | | Gastric Ulcers | | | Headaches/Migraines | | |
| Stroke | | | Blood Disorder | | | Malnutrition | | | Psychiatric Condition | | |
| Congest. Heart Failure | | | HIV/AIDS | | | Eating Disorder | | | Glaucoma | | |
| Congenital Heart Dis. | | | Autoimmune Dis. | | | Thyroid Disease | | | Osteoporosis | | |
| Heart Murmur | | | Osteoarthritis | | | Kidney Disease | | | Rapid Weight Loss | | |
| Low Blood Pressure | | | Rheum. Arthritis | | | Alcoholism | | | STD | | |
| High Blood Pressure | | | Lupus | | | Drug Addiction | | | Night Sweats | | |
| Mitral Valve Prolapse | | | Bronchitis | | | Diabetes- I & II | | | Excessive Urination | | |
| Pacemaker | | | Asthma | | | Cancer | | | Smoking | | |
| Artificial Heart Valve | | | COPD | | | Chemotherapy | | | Shingles | | |
| Rheumatic Fever | | | Emphysema | | | Radiation | | | Artificial Joints | | |
| Rheum. Heart Disease | | | Chr. Liver Dis. | | | Epilepsy | | | Alzheimer's Disease | | |
| Excessive Bleeding | | | Cirrhosis | | | Seizures | | | Cortisone Therapy | | |
| Anemia | | | Hepatitis B or C (circle type) | | | Fainting/Dizziness | | | Hay Fever | | |

Any other illness that is not listed above? If "yes," please explain: _____

Preferred Pharmacy _____

Emergency contact: _____ **Relationship:** _____ **Phone: (____) _____**

For women only: Are you:

Pregnant/Trying to get pregnant? Y N

Nursing? Y N

Taking oral contraceptives? Y N

Acknowledgement

I attest that the information given above is accurate and truthful. I understand that providing incorrect information or withholding information can be dangerous to my (or the patient's) health. It is my responsibility to inform D.A. Dental of any changes in the medical status.

Print name: _____ Signature: _____

Parent or Guardian Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____