

# Health History Form

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|                       |               |
|-----------------------|---------------|
| E-mail:<br>(Required) | 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:<br>Last First Middle  |  | Home Phone: <i>Include area code</i><br>( ) -    |              | Business/Cell Phone: <i>Include area code</i><br>( ) - |   |
| Address:<br>Mailing Address   |  |  | City:        | State:   | Zip:  |
| Employer and Occupation:  |  |  | Height:      | Weight:  | Date of birth:  |
| SS # :  |  | Emergency Contact & Phone #:<br>Name Phone#( ) - |              | Relationship:  | Sex: M F<br><input type="checkbox"/> Single<br><input type="checkbox"/> Married |
| Home Phone:<br>( ) include area code  |  | Cell Phone:<br>( )                               |              |  |   |
| If you are completing this form for another person, what is your relationship to that person? |  |  |              |  |   |
| Your Name   |  |  | Relationship |  |   |

## Policy Holder and Insurance Information

|                       |  |                    |       |                         |                                     |
|-----------------------|--|--------------------|-------|-------------------------|-------------------------------------|
| Policy Holder's Name: |  | Date of Birth:     |       | SS#                     |                                     |
| Address:              |  |                    | City: | State:                  | Zip:                                |
| Employer Name:        |  | Insurance Company: |       | Group or Policy Number: | Insurance Company Phone #:<br>( ) - |

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

|   |   |
|---|---|
| <p>How did you hear about our Dental Office?<br/> <input type="checkbox"/> Insurance Company <input type="checkbox"/> Referral: Who? _____ <input type="checkbox"/> Website <input type="checkbox"/> Postcard<br/> <input type="checkbox"/> Drive By <input type="checkbox"/> Newspaper a. Viera Voice <input type="checkbox"/> Other _____<br/>                 b. Home Town News<br/>                 c. Other</p> <p>(CC) <span style="float: right;">Yes No DK</span><br/>                 What is the <b>reason</b> of today's visit? _____<br/>                 When was the <b>last time</b> you saw a dentist? _____<br/>                 Are you in any <b>pain</b> today or in the past? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>(Anxiety)<br/>                 Are you <b>nervous</b> during dental visits? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Are you <b>interested</b> in learning how we can <b>reduce your nervousness</b> with nitrous oxide "laughing" gas or conscious sedation (pills/IV) ? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>(Perio)<br/>                 Has a previous dentist diagnosed you with <b>Periodontal "Gum" Disease</b>? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Do your gums <b>bleed</b> when brushing or flossing? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Does food or floss <b>catch</b> between your teeth? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Have you ever had <b>scaling or root planning</b> in the past? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Have you ever had <b>gum surgery</b>? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Do you have <b>gum recession</b>? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Do you have <b>loose teeth</b>? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Do you have <b>bad breath</b>? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Are you aware that <b>Periodontal Disease</b> affects your body health? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Would you like <b>more information</b> on <b>Periodontal Disease</b>? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>(TMJ)<br/>                 Has anyone ever told you that you <b>grind or clench</b> your teeth? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Does your <b>jaw joint "pop" or click</b> when opening, eating, or yawning? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Do you have <b>pain</b> in your <b>jaw joint</b>? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Are your <b>jaw muscles</b> ever sore in the morning? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Do you have <b>sore teeth</b> in the morning or wake up with <b>headaches</b>? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Have you ever worn a <b>night guard</b> to protect your teeth? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Would you like <b>more information</b> on how a <b>night guard</b> can reduce your pain, headaches, and grinding/clenching habit? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>(Oral Cancer)<br/>                 Do you <b>smoke</b> (cigarettes, cigars, pipes, drugs) or <b>chew tobacco</b>? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 How many per day? ____ How many years? ____</p> | <p>Yes No DK</p> <p>Do you drink <b>alcoholic beverages</b>? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 How many per day? ____ How many per week? ____<br/>                 Have you noticed any <b>color changes</b> of the <b>tissues</b> in or around your mouth? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Have you noticed any <b>lumps or bumps</b> in or around your mouth? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Have you ever performed an <b>Oral Cancer Screening</b> at the Dentist? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Are you interested in performing an <b>oral cancer screening</b> at the Dentist? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>(Teeth)<br/>                 Are you having any <b>problems</b> with your teeth? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Are your teeth <b>sensitive to colds, hots, or sweets</b>? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Local to one area? <input type="checkbox"/> All of your teeth? <input type="checkbox"/><br/>                 Do you have any <b>cracked, chipped, or broken teeth</b>? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Do you have any <b>tooth pain</b> while eating? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Have you noticed any <b>dark spots</b> on your teeth? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>(Cosmetic)<br/>                 Would you <b>improve anything</b> about your smile, gums or teeth? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Explain: _____<br/>                 Would you like <b>whiter teeth</b>? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Would you like <b>straighter or less spaced teeth</b>? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Would you like <b>perfectly contoured teeth</b>? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Would you like an <b>opportunity to view</b> your teeth in a <b>"New Smile"</b> that is generated in our <b>cosmetic computer software</b>? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Would you like <b>more information</b> on:<br/>                 • Whiter Teeth ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 • Straighter Teeth ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 • Perfectly shaped Teeth ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 • Any other Cosmetic Procedure ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>(Dentures)<br/>                 Do you wear <b>partials or complete dentures</b>? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Do they cause <b>irritation or pain</b>? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Do your dentures <b>move or rock</b> when eating or speaking? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Do you <b>eat well</b> with them in place? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Do you <b>like</b> their <b>appearance</b> when you smile? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Do you <b>wear</b> them? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br/>                 Are you interested in learning how <b>Dental Implants</b> can replace your your dentures or partials permanently? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> |
|---|---|

**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<br>Are you now under the care of a physician? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Physician Name: _____ Phone: Include area code _____<br>( ) _____<br>Has there been any change in your general health within the past year? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>If yes, what condition is being treated?<br>_____<br>Date of last physical exam: _____ | Please list every surgery and date performed.<br>_____<br>_____<br>Please list every medicine you take and why you are taking the medicine.<br>_____<br>_____<br>_____ |
|--|--|

|   |   |
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| Yes No DK<br><b>Joint Replacement.</b> Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Date: _____ If yes, have you had any complications? _____ | Yes No DK<br>Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Date Treatment began: _____ |
|---|---|

|  |   |
|--|---|
| Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risdedronate (Actonel®) for osteoporosis or Paget's disease? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Yes No DK<br><b>WOMEN ONLY</b> Are you:<br>Pregnant? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Number of weeks: _____<br>Planning to get pregnant soon? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Taking birth control pills or hormonal replacement? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Nursing? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
|--|---|

|   |  |
|---|--|
| <b>Allergies</b> - Are you allergic to or have you had a reaction to:<br>To all yes responses, specify type of reaction.<br>Local anesthetics _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Aspirin _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Penicillin or other antibiotics _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Barbiturates, sedatives, or sleeping pills _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Sulfa drugs _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Codeine or other narcotics _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Bleach _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Yes No DK<br>Metals _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Latex (rubber) _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Iodine _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Hay fever/seasonal _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Animals _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Food _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Other _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
|---|--|

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

|   |   |
|---|---|
| Yes No DK<br>Artificial (prosthetic) heart valve ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Previous infective endocarditis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Damaged valves in transplanted heart ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Congenital heart disease (CHD)<br>Un repaired, cyanotic CHD..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Repaired (completely) in last 6 months..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Repaired CHD with residual defects ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.  | Yes No DK<br>Autoimmune disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Rheumatoid Arthritis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Systemic lupus erythematosus ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Asthma ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Bronchitis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Emphysema ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Sinus trouble..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Tuberculosis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Cancer/Chemotherapy/<br>Radiation Treatment..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Chest pain upon exertion..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Chronic Pain ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Diabetes Type I or II..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Eating disorder..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Malnutrition..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Gastrointestinal disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Acid Reflux/persistent<br>heartburn ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Ulcers ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Thyroid problems ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Stroke ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Glaucoma ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Yes No DK<br>Cardiovascular disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>High Cholesterol ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Angina..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Arteriosclerosis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Congestive heart failure..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Damaged heart valves ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Heart attack ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Heart murmur ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Low blood pressure ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>High blood pressure ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Other congenital heart<br>defects..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Yes No DK<br>Mitral valve prolapse..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Pacemaker ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Rheumatic fever ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Rheumatic heart disease..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Abnormal bleeding ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Anemia ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Blood transfusion ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>If yes, date: _____<br>Hemophilia ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>AIDS or HIV infection ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Arthritis..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>   |

Hepatitis, jaundice or liver disease .....     
 Epilepsy .....     
 Fainting spells or seizures .....     
 Neurological disorders .....     
 If yes, specify: \_\_\_\_\_  
 Sleep disorder.....     
 Anxiety .....     
 Depression .....     
 Recurrent Infections.....     
 Type of infection: \_\_\_\_\_  
 Kidney problems .....     
 Night sweats .....     
 Osteoporosis .....     
 Persistent swollen glands  
 in neck.....     
 Severe headaches/  
 migraines .....     
 Severe or rapid weight loss.....     
 Sexually transmitted disease...     
 Excessive urination.....     
 Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? .....     
 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 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: \_\_\_\_\_  
 \_\_\_\_\_