FAIRVIEW DENTAL ARTS

HEALTH HISTORY FORM

Name: Home Phone: ( ) Business Phone: ( )

Address: City: State: Zip:

Occupation: Height: Weight: D.O.B. / / Sex: M ☐ F ☐

SS Number: Emergency Contact: Relationship: Phone: ( )

If you are completing this form for another person, what is your relationship with that person?

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit 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.

DENTAL INFORMATION

	YES	NO	DON'T KNOW
Do your gums bleed when you brush?	☐	☐	☐
Have you ever have orthodontic (braces) treatment?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Do you have earaches or neck pains?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Do you wear removable dental appliances?	☐	☐	☐
Have you had a serious/difficult problem associated with any previous dental treatments?	☐	☐	☐

If yes, please explain: _____

How would you describe your current dental problem?

_____

Date of your last dental exam: _____

Date of your last dental x-ray: _____

What was done at that time? _____

How do you feel about the appearance of your teeth?

_____

MEDICAL INFORMATION

	YES	NO	DON'T KNOW
If you answer YES to any of the3 items below, please stop and return this form to the receptionist.			
Have you had any of the following diseases or problems?			
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐
Are you now under the care of a physician?	☐	☐	☐

If yes, what is/are the condition(s) being treated?

_____

_____

Date of last physical examination: _____

Physician:_____

Name:_____ Phone: (____)_____

Address:_____ City/State:_____Zip:_____

	YES	NO	DON'T KNOW
Have you had any serious illness, operation, or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

_____

_____

	YES	NO	DON'T KNOW
Are you taking or have you recently taken any medicine(s) including non-prescription medicine?	☐	☐	☐

If yes, what medicine(s) are you taking?

Prescribed: _____

Over the counter: _____

Vitamins, natural or herbal preparations and/or diet supplements:

_____

	YES	NO	DON'T KNOW
Are you taking, or have you taken, any diet drugs such As Pondimin (fenfluramine0phentermine combination?)	☐	☐	☐
Do you drink alcoholic beverages?	☐	☐	☐

If yes, how much alcohol did you drink in the last 24 hours?

_____

In the past week? _____

	YES	NO	DON'T KNOW
Are you alcohol and/or drug dependent?	☐	☐	☐

If yes, have you received treatment? (circle one) YES / NO

	YES	NO	DON'T KNOW
Do you use drugs or other substances for recreational purposes?	☐	☐	☐

If yes, please list: _____

Frequency of use (daily, weekly, etc.):_____

Number of years of recreational drug use: _____

	YES	NO	DON'T KNOW
Do you use tobacco (smoking, snuff, chew)?	☐	☐	☐

If yes, how interested are you in stopping?

(circle one) Very / Somewhat / Not Interested

	YES	NO	DON'T KNOW
Do you wear contact lenses?	☐	☐	☐

PLEASE COMPLETE BOTH SIDES

MEDICAL INFORMATION (continued)

Are you allergic to or have you had a reaction to?	YES	NO	DON'T KNOW
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotic	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Latex	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food (specify)_____	☐	☐	☐
Other (specify)_____	☐	☐	☐
Metals (specify)_____	☐	☐	☐

To yes responses, specify type of reaction: _____
_____
_____
_____

	YES	NO	DON'T KNOW
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐

If yes, when was this operation done? _____

If you answered yes to the above question, have you had any complications or difficulties with your prosthetic joint?

_____
_____

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

If yes, what antibiotic and dose?_____

Name of physician or dentist: _____

Phone: (___)_____

WOMEN ONLY

Are you or could you be pregnant?	☐	☐	☐
Nursing?	☐	☐	☐
Taking birth control pills or hormonal replacement?	☐	☐	☐

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

	YES	NO	DON'T KNOW
Abnormal bleeding	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Anemia	☐	☐	☐
Arthritis	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Asthma	☐	☐	☐
Blood transfusion (*if yes, date*):_____	☐	☐	☐
Cancer/Chemotherapy/Radiation Treatment	☐	☐	☐
Cardiovascular disease (*if yes, specify below*):	☐	☐	☐
_____ Angina	_____ Heart murmur		
_____ Arteriosclerosis	_____ High blood pressure		
_____ Artificial heart valves	_____ Low blood pressure		
_____ Congenital heart defects	_____ Mitral valve prolapse		
_____ Congestive heart failure	_____ Pacemaker		
_____ Coronary artery disease	_____ Rheumatic heart disease/Rheumatic fever		
_____ Damaged heart valves			
_____ Heart attack			
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Disease, drug, or radiation-induced immunosuppression	☐	☐	☐
Diabetes (*if yes, specify below*):	☐	☐	☐
_____ Type I (insulin dependent) _____ Type II			
Dry mouth	☐	☐	☐
Eating disorder (if yes, please specify): _____	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Glaucoma	☐	☐	☐

	YES	NO	DON'T KNOW
Hemophilia	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Recurrent infections	☐	☐	☐
If yes, indicate type of infection: _____			
Kidney problems	☐	☐	☐
Mental health disorders (*if yes, specify*): _____	☐	☐	☐
Malnutrition	☐	☐	☐
Night sweats	☐	☐	☐
Neurological disorders (*if yes, specify*): _____	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Respiratory problems (*if yes, specify below*):	☐	☐	☐
_____ Emphysema _____ Bronchitis, etc.			
Severe headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Sinus trouble	☐	☐	☐
Sleep disorder	☐	☐	☐
Sores or ulcers in the mouth	☐	☐	☐
Stroke	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Tuberculosis	☐	☐	☐
Thyroid problems	☐	☐	☐
Ulcers	☐	☐	☐
Excessive urination	☐	☐	☐

Do you have any disease, condition, or problem Not listed above that you think I should know about? ☐ ☐ ☐

If yes, 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. 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 on patient interview concerning health history:

Significant Findings from questionnaire or oral interview:

Dental management considerations:

Health History Update: On a regular basis the patient should be questioned about any medical history changes, date and comments notated, along with signature.

Date:_____ Comments:_____ Signature of patient and dentist:_____