HEALTH HISTORY

As required by law, our office adheres to written policies and procedures to protect the privacy of the 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: First **Last**

Birth Date Age: Today's Date:

Answer all questions by checking Y (yes) or N (no). ALL RESPONSES ARE KEPT CONFIDENTIAL.

Previous Dentist: Last Dental Appt: Height: Weight:

If you are completing this form for another person, what is your name? Relationship:

Are you apprehensive about dental work? ☐ No ☐ Slight ☐ Moderate ☐ Extreme

I brush _____ times per day and floss _____ times per day.

How often do you visit the dentist? ☐ Never ☐ Toothaches ☐ Checkups ☐ Regularly

Y	N	
☐	☐	Are you in good health? Date of last physical exam?
☐	☐	Have you had any serious problems associated with previous dental treatment?
☐	☐	Are you currently in pain? Do your gums ever bleed? Y ☐ N ☐
☐	☐	Has there been any change in your general health in the past year?
☐	☐	Are you interested in sedation dentistry? ☐ Implants ☐ Teeth Whitening ☐ Orthodontics
☐	☐	Have you ever had any serious illnesses, operations, or hospitalizations?
☐	☐	Are you now under a physician's care for a particular problem? Personal Physician:
☐	☐	Have you or an immediate family member had any problem associated with Intravenous Sedation or General Anesthesia?

DO YOU HAVE OR HAVE YOU EVER HAD:

Y	N		Y	N		Y	N	
☐	☐	Acid Reflux/Heartburn	☐	☐	COPD	☐	☐	High Blood Pressure
☐	☐	Alzheimers/Dementia	☐	☐	Congestive Heart Failure	☐	☐	HIV/AIDS
☐	☐	Asthma	☐	☐	Clicking or Popping of Jaw	☐	☐	Hearing loss
☐	☐	Arthritis	☐	☐	Cancer	☐	☐	Jaundice
☐	☐	Anxiety	☐	☐	Crohn's	☐	☐	Kidney Disease
☐	☐	Angina	☐	☐	Celiac Disease	☐	☐	Low Blood Pressure
☐	☐	Anemia	☐	☐	Diabetes	☐	☐	Liver Disease
☐	☐	Artificial Heart Valve	☐	☐	Depression	☐	☐	Lung Disease
☐	☐	Artificial Joint Replacement	☐	☐	Developmental Disability	☐	☐	Mental Illness
☐	☐	Autism/Asberger's	☐	☐	Difficulty Opening Mouth	☐	☐	Mitral Valve Prolapse
☐	☐	Auto Immune Disease	☐	☐	Difficulty Breathing	☐	☐	Multiple Sclerosis
☐	☐	Bleeding Disorder	☐	☐	Eating Disorder	☐	☐	Osteoprosis
☐	☐	Bruise Easily	☐	☐	Epilepsy/Seizures	☐	☐	Pacemaker
☐	☐	Blood Transfusion	☐	☐	Emphysema	☐	☐	Pain Near Ear
☐	☐	Cardiovascular Disease	☐	☐	Fainting or Dizziness	☐	☐	Radiation/Chemotherapy
☐	☐	ChronicTuberculosis	☐	☐	Glaucoma	☐	☐	Sinus or Nasal problems
☐	☐	Chest Pain	☐	☐	Grinding or Clenching Teeth	☐	☐	Stroke/TIA
☐	☐	Congenital Heart Disease	☐	☐	Heart Issues	☐	☐	Sleep Disorders
☐	☐	Coronary Artery Disease	☐	☐	Hepatitis	☐	☐	Thyroid Disease

Other: _____

_____

ARE YOU USING ANY OF THE FOLLOWING MEDICATIONS?

Y	N	
☐	☐	Antibiotics
☐	☐	Anti-Coagulents (blood thinners, Coumadin, ect.)
☐	☐	NSAIDs (Asprin, Tylenol, Aleve, Motrin, Ibuprofen, Naproxen)
☐	☐	High Blood Pressure Medications
☐	☐	Steroids (Cortisone, Prednisone, ect.)
☐	☐	Insulin or Oral Anti-Glycemic Medications
☐	☐	Anti-depressants or Tranquilizers
☐	☐	Digitalis, Inderal, Nitroglycerin or other heart medications
☐	☐	Biphosphonate medications current or previous (Fosamax, Boniva, Actonel, Dridronel, ect.)
☐	☐	Do you take any prescription medications, over the counter medications, herbal, holistic remedies, vitamins or minerals? Please list if yes.

_____

_____

ARE YOU ALLERGIC TO OR HAVE HAD AN ADVERSE REACTION TO:

Y	N		Y	N	
☐	☐	Local Anesthesia (Novocain, ect.)	☐	☐	Latex or Rubber Products
☐	☐	Penicillin or other antibiotics	☐	☐	Narcotics, Codeine, or other pain killers
☐	☐	Sedatives, Barbiturates, or Sleeping Pills	☐	☐	Metals or Iodine
☐	☐	Asprin, Ibuprofen, or other NSAIDS	☐	☐	Gluten Products
☐	☐	Other allergies or Reactions? Please list:	☐	☐	Sulfa

_____

Y	N	
☐	☐	Do you smoke/ Chew? If yes, how long? _____ How much per day? _____
☐	☐	Do you have a current or past dependency on alcohol?
☐	☐	Do you have a current past chemical dependency (marijuana, methamphetamine, cocaine, narcotics.)?
☐	☐	Do you have a current or past emotional disorder?
☐	☐	Do you have any other disease, condition or problem not listed above that you think the doctor should know about?
☐	☐	Do you wish to talk to the doctor privately for anything?

☐	☐	Are you pregnant or is there any chance you might be pregnant?
☐	☐	Are you nursing?

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant health issues prior to 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.

Date

Signature of Patient or Legal Guardian completing Health History Doctors Signature