

Medical Alert	Conditions	Prescription	Allergies	Anesthetics	Date:
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HEALTH HISTORY FORM

Name: _____ Home Phone: () _____ Cell Phone: () _____
 Address: _____ City: _____ State: _____ Zip Code: _____
P.O. BOX or Mailing Address
 Occupation: _____ Height: _____ Weight: _____ Date of Birth: _____ Sex: M F
 SS#: _____ Emergency Contact: _____ Relationship: _____ Phone: () _____

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

Email Address (Please Print) _____ NAME _____ RELATIONSHIP _____

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

Do your gums bleed when you brush?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	How would you describe your current dental problem?
Have you ever had orthodontic (braces) treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	_____
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	Date of your last dental exam:
Do you have earaches or neck pains?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	_____
Have you had any periodontal (gum) treatments?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	Date of last dental x-rays:
Do you wear removable dental appliances?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	_____
Have you had a serious/difficult problem associated with any previous dental treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	What was done at that time?
If yes, explain: _____		_____
		How do you feel about the appearance of your teeth?

MEDICAL INFORMATION

If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.		Are you taking or have you recently taken any medicine(s) including non-prescription medicine?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Have you had any of the following diseases or problems?		If yes, what medicine(s) are you taking?	
Active Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	Prescribed:	
Persistent cough greater than a 3 week duration	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	Over the counter:	
Cough that produces blood	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	Vitamins, natural or herbal preparations and/or diet supplements:	
Are you in good health?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Has there been any change in your general health within the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	Do you drink alcoholic beverages?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Are you now under the care of a physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	If yes, how much alcohol did you drink in the last 24 hours?	
If yes, what is/are the condition(s) being treated?		In the past week?	
_____		Are you alcohol and/or drug dependent?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Date of last physical examination: _____		If yes, have you received treatment? (circle one) Yes / No	
Physician:		Do you use drugs or other substances for recreational purposes?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
NAME _____ PHONE _____		If yes, please list:	
ADDRESS _____ CITY/STATE _____ ZIP _____		Frequency of use (daily, weekly, etc.): _____	
NAME _____ PHONE _____		Number of years of recreational drug use: _____	
ADDRESS _____ CITY/STATE _____ ZIP _____		Do you use tobacco (smoking, snuff, chew)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Have you had any serious illness, operation, or been hospitalized in the past 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	If yes, how interested are you in stopping? (circle one) Very / Somewhat / Not interested	
If yes, what was the illness or problem?		Do you wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know

