Health History Form

ADA American Dental Association®

Patient Name:_____

Date of Birth: _____

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.

Dental Information: Please mark (X) Yes, No or DK (don't know) for all the questions below.

	Yes	No	DK
Do your gums bleed when you brush of floss?	□	□	□
Are your teeth sensitive to cold, hot, sweets or pressure? ……	□	□	□
Does food or floss catch between your teeth?	□	□	□
Is your mouth dry? ……	□	□	□
Have you had any periodontal (gum) treatments?	□	□	□
Have you had orthodontic treatment/braces? …	□	□	□
Have you ever had any problems associated with previous dental treatment? ……..	□	□	□
Is your home water supply fluoridated? …….	□	□	□
Do you drink bottled or filtered water? ……	□	□	□

If yes how often? Circle one: Daily / Weekly / Occasionally

	Yes	No	DK
Are you currently experiencing dental pain or discomfort? ……	□	□	□

How do you feel about your smile?

_____

	Yes	No	DK
Do you have earaches or neck pains? ……..	□	□	□
Do you have clicking, popping or discomfort in the jaw? ……..	□	□	□
Do you brux or grind your teeth? (clench) ……..	□	□	□
Do you wear a nightguard? ……..	□	□	□
Do you have sores or ulcers in your mouth? ….	□	□	□
Do you wear dentures or partials? ……..	□	□	□
Do you participate in active recreational activities? ……..	□	□	□
Have you ever had a serious injury to your head or mouth? ……..	□	□	□

What is the reason for your dental visit today?

_____

Date of your last dental exam: _____

What was done at that time? _____

_____

Date of last dental x-rays: _____

Medical Information: Please mark (X) Yes, No or DK (don't know) for all the questions below.

	Yes	No	DK
Are you under the care of a physician? …….	□	□	□

Physician Name:

_____( ) _____

Address/City Zip

_____

	Yes	No	DK
Are you in good health? ……	□	□	□
Has there been any change in your general health within the last year? ……	□	□	□

If yes, what condition is being treated? _____

_____

Date of last physical exam: _____

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years? ……	□	□	□

If yes, what was the illness or problem? _____

_____

	Yes	No	DK
Are you taking or have you recently taken any prescription or over the counter medicines? …..	□	□	□

If so, please list all, including vitamins, natural or herbal preparations, diet supplements or recreational drugs?

_____

_____

_____

Patient /Legal Guardian Initials: _____

Medical Information: Please mark (X) Yes, No or DK (don't know) for all the questions below.

Patient Name: _____

	Yes	No	DK
Do you wear contact lenses? ……..	□	□	□
Joint Replacement: Have you had an Orthopedic total joint replacement (hip knee, elbow finger, shoulder)? ……	□	□	□
If yes: Date: _____			
Have you had any complications?_____			
_____			
Are you taking or scheduled to begin taking An antiresorptive agent (like Fosamax ®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? ……..	□	□	□
Since 2001, were you treated or are you presently scheduled to begin treatment with an anitresorptive agent (like Aredia®, Zometa®, XGeva) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	□	□	□
Date treatment began: _____			

Allergies- Are you allergic to or have you had a reaction to:

To all yes responses specify type of reaction.	Yes	No	DK
Local anesthetic _____	□	□	□
Aspirin _____	□	□	□
Penicillin _____	□	□	□
Barbiturates, sedatives or sleeping pills ___	□	□	□
Sulfa drugs _____	□	□	□
Codeine or other narcotics _____	□	□	□
Metals _____	□	□	□
Latex (rubber) _____	□	□	□
Hay fever/seasonal _____	□	□	□
Other _____	□	□	□

Do you use controlled substances? ……..	□	□	□
Do you use tobacco (smoking, snuff , chew) …	□	□	□
If so are you interested in stopping? Circle one Very / Somewhat/ Not Interested			
Do you drink alcohol? ……	□	□	□
If yes, how much do you typically drink in a week? _____			

Women Only: Are you

Pregnant ……	□	□	□
If yes, number of weeks _____			
Nursing ……..	□	□	□
Taking birth control pills / hormone replacement?	□	□	□

Diseases or Problems	Yes	No	DK
Artificial (prosthetic) heart valve ……..	□	□	□
Previous infective endocarditis ……	□	□	□
Damaged valves in transplanted heart …….	□	□	□
Congenital heart disease (CHD)	Yes	No	DK
Unrepaired, cyanotic CHD ……	□	□	□
Repaired (completely) in last 6 months …...	□	□	□
Repaired CHD with residual defects …….	□	□	□
Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.			
Cardiovascular disease ……	□	□	□
Angina ……..	□	□	□
Arteriosclerosis ……..	□	□	□
Congestive heart failure ……	□	□	□
Damaged heart valves ……..	□	□	□
Heart attack ……	□	□	□
Heart murmur ……	□	□	□
Low blood pressure ……	□	□	□
High blood pressure ……	□	□	□
Other congenital heart defects ……..	□	□	□
Mitral valve prolapse ……	□	□	□
Pacemaker ……	□	□	□
Rheumatic fever ……	□	□	□
Rheumatic heart disease ……	□	□	□
Abnormal bleeding ……	□	□	□
Blood transfusion ……..	□	□	□
If yes, date: _____			
Hemophilia ……	□	□	□
Aids or HIV infection ……	□	□	□
Arthritis ……	□	□	□
Autoimmune disease ……	□	□	□
Rheumatoid arthritis ……	□	□	□
Systemic lupus erythematosus ……	□	□	□
Asthma ……	□	□	□
Bronchitis ……	□	□	□
Emphysema ……	□	□	□
Sinus trouble ……..	□	□	□
Tuberculosis ……..	□	□	□
Cancer/Chemotherapy/Radiation Treatment ...	□	□	□
Chest pain upon exertion ……	□	□	□
Chronic pain ……..	□	□	□
Diabetes Type I or II ……	□	□	□
Eating disorder ……	□	□	□
Malnutrition ……	□	□	□
Gastrointestinal disease ……...	□	□	□
G.E. Reflux/persistent heartburn ……..	□	□	□
Ulcers ……	□	□	□
Thyroid problems ……..	□	□	□
Stroke ……	□	□	□
Glaucoma ……	□	□	□
Hepatitis, jaundice or liver disease ……..	□	□	□
Epilepsy ……	□	□	□

Patient/Legal Guardian Initials _____

Patient Name: _____

	Yes	No	DK
Fainting spells or seizures ……	☐	☐	☐
Neurological disorders ……..	☐	☐	☐
If yes, specify: _____			
Sleep disorder ……	☐	☐	☐
Mental disorder ……..	☐	☐	☐
If yes, specify: _____			
Recurrent infections ……..	☐	☐	☐
Type of infection: _____			

	Yes	No	DK
Kidney problems ……	☐	☐	☐
Night sweats ……	☐	☐	☐
Osteoporosis ……	☐	☐	☐
Persistent swollen glands in neck ……..	☐	☐	☐
Severe headaches/migraines ……	☐	☐	☐
Severe or rapid weight loss ……..	☐	☐	☐
Sexually transmitted disease ……	☐	☐	☐
Excessive urination ……	☐	☐	☐

Do you know or have you been told you snore? ☐ Yes ☐ No

Have ever been diagnosed with sleep apnea? ☐ Yes ☐ No Do you or have you used a CPAP machine? ☐ Yes ☐ No

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ……	☐	☐	☐

Name of physician or dentist making recommendation _____Phone: _____

Do you have any disease, condition, or problems 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 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 inquires 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.

I hereby authorize the doctors at Courtyard Dental Care or their certified staff members to take radiographs, study models, photographs or perform any other diagnostic procedures deemed appropriate by the doctors.

_____

Signature of Patient/Legal Guardian Date

For Completion by Dentist

Comments:_____

_____

_____

_____

Dentist Signature Date

Medical History Updated

1. Date: _____ Initials: _____ 3. Date: _____ Initials: _____ 5. Date: _____ Initials: _____

2. Date: _____ Initials: _____ 4. Date: _____ Initials: _____ 6. Date: _____ Initials: _____