

A thorough health history is essential for good diagnosis and treatment and will allow us to provide you with the best dental care. All information is confidential in accordance with HIPAA (Health Insurance Portability and Accountability Act) legislation. We appreciate your cooperation. PLEASE PRINT.

Name: _____ Date: _____

Date of Birth: _____ SSN: _____

Family Status: S M D W Gender: M F

Address: _____ City/State/Zip: _____

Phone: _____ Work: _____ Cell: _____

E-Mail: _____ Employer: _____

EMERGENCY CONTACT: _____ **Phone:** _____

With whom may we discuss your treatment? (ie: Spouse, Family Member) _____

Person responsible for payment: _____ Dental Insurance? Yes No

Insurance Company _____ I.D. # _____

PLEASE ANSWER YES OR NO TO ALL THE FOLLOWING:

Are you in good health? Yes No

Have you seen a physician or other healthcare professional for **ANY** consultation, treatment, therapy, or surgery? Yes No

PLEASE DESCRIBE TREATMENT RENDERED: _____

Physicians Name: _____ Physicians Telephone: _____

Have you suffered any illness or injury? Yes No

PLEASE DESCRIBE YOUR ILLNESS OR INJURY: _____

PLEASE LIST ALL MEDICATIONS (Prescription, Over the counter, Supplements, Herbal and Dietary)

Do you smoke or use smokeless tobacco? Yes No How Long? _____

Do you use recreational drugs? (ie: cocaine, marijuana, ecstasy, etc.) Yes No

Have you ever been addicted to prescription drugs? Yes No

Do you utilize healthy dietary habits? Yes No

Are you in a high risk group for HIV infection?

(I.V. drug use, recipient of blood products, multiple sexual relationships, homosexual) Yes No

Have you been diagnosed with AIDS or HIV infection? Yes No

Have you ever been told by a physician to be pre-medicated with

antibiotics prior to dental treatment? Yes No

Do you have any immune disorder? Yes No

Have you had any treatment or taken any medications

that make you prone to infection? (Steroids, Chemotherapy, etc.) Yes No

Do you participate in sports or activities that might

lead to oral trauma? (ie: boxing, basketball, football, snowboarding) Yes No

Do you snore? Yes No

When you wake do you feel refreshed? Yes No

Has anyone noted difficulty in your breathing patterns at night? Yes No

Do you find you are excessively tired during the day? Yes No

Women:	Are you pregnant?	Yes	No
	Are you nursing?	Yes	No
	Do you take oral contraceptives?	Yes	No
	Do you have osteoporosis?	Yes	No

Do you have or have you had any of the following?

Arrhythmia	Yes	No	Immune Disorder	Yes	No
Chest Pain	Yes	No	Hepatitis A B C D	Yes	No
Shortness of breath	Yes	No	Jaundice or Liver Disease	Yes	No
Angina	Yes	No	Tuberculosis (TB)	Yes	No
Rheumatic Fever	Yes	No	HIV or AIDS	Yes	No
Heart Murmur	Yes	No	Sexually Transmitted Disease	Yes	No
Congestive Heart Failure	Yes	No	Herpes Infection	Yes	No
Mitral Valve Prolapse	Yes	No	Kidney Disease	Yes	No
Congenital Heart Defect	Yes	No	Thyroid Disease	Yes	No
Heart Attack	Yes	No	Stomach Problems (ulcer)	Yes	No
Coronary Artery Disease	Yes	No	Gastroesophageal Reflux (GERD)	Yes	No
Heart Surgery	Yes	No	Anemia	Yes	No
Angioplasty or Stents	Yes	No	Bleeding Disorders	Yes	No
Stroke	Yes	No	Transfusion/Year_____	Yes	No
High Blood Pressure	Yes	No	Arthritis	Yes	No
Low Blood Pressure	Yes	No	Rheumatoid Arthritis	Yes	No
Valve Replacement	Yes	No	Osteoarthritis	Yes	No
Pacemaker	Yes	No	Joint Replacement	Yes	No
Internal Defibrillator	Yes	No	(Hip, Knee, Ankle, Finger, etc.)		
Endocarditis	Yes	No	Organ Replacement (Kidney, etc.)	Yes	No
Cancer	Yes	No	Parkinson's Disease	Yes	No
Radiation Treatment	Yes	No	Alzheimer's Disease	Yes	No
Chemotherapy	Yes	No	Dementia	Yes	No
Asthma	Yes	No	Neck or Back Injury	Yes	No
Pulmonary Disease (COPD)	Yes	No	Neurologic or Nerve Disorders	Yes	No
Glaucoma	Yes	No	Epilepsy or Seizures	Yes	No
Sinus Problems	Yes	No	Dizziness/Fainting	Yes	No
Sleep Disorders	Yes	No	Depression	Yes	No
Diabetes	Yes	No	Osteoporosis/Osteopenia	Yes	No

Are you allergic to any of the following?

Antibiotics (Penicillin, Erythromycin, Sulfa drugs)	Yes	No	Which antibiotic? _____
Aspirin	Yes	No	
Anesthetics like Novocaine	Yes	No	
Latex	Yes	No	
Iodine	Yes	No	
Barbiturates	Yes	No	
Sedatives	Yes	No	
Codeine	Yes	No	
Metals (costume jewelry, etc.)	Yes	No	
Epinephrine (adrenaline)	Yes	No	
Other _____	Yes	No	

Have you **ever** taken any oral or I.V. bone building medications due to poor bone density, osteopenia, or osteoporosis?

(ie Fosamax, Boniva, Actonel, Aredia, Zometa, Bonfex, Reclast, Evista, etc.)

Yes No

Do you bruise easily?

Yes No

Have you ever experienced problems healing?

Yes No

Have you ever had any problems with an eating disorder? (Anorexia, Bulimia)

Yes No

Do you ever notice a sour taste in your mouth?

Yes No

Do you have any habits that might contribute to tooth fracture or wear?

Yes No

Circle Below

Ice Chewing Nail Biting Gum Chewing Soda or Diet Soda Intake Toothpaste overuse
Chewing Objects Cast Netting Frequent Sports Drink Intake Frequent Juice Intake

Do you like your smile? Yes No

How would you change it? _____

Who may we thank for referring you? _____

Previous Dentist _____

Have you ever had a poor dental experience? _____

Please describe what happened. _____

Have you noticed...

Frequent Mouth Sores	Yes	No	Burning Mouth Syndrome	Yes	No
Teeth Tender To Chew On	Yes	No	Bad Breath	Yes	No
Bleeding Gums	Yes	No	Change In Color of Teeth	Yes	No
Gum Infection	Yes	No	Change In Color of Gums	Yes	No
Spaces Developing Between Teeth	Yes	No	Teeth Sensitive (Heat, Cold, Sweets)	Yes	No
Swelling or Lump In Mouth	Yes	No	Bite Problems	Yes	No
Clenching or Grinding Teeth	Yes	No	Clicking or Popping Jaw Joint	Yes	No
Limited Jaw Movement or Locking	Yes	No	Pain in Jaw Joint	Yes	No

Have you been diagnosed with gum disease, periodontal disease, or pyorrhea? Yes No

Do you floss? Yes No How Often _____

When was your last dental cleaning? _____

List any dental hygiene devices that you use regularly: _____

How often and how long do you brush your teeth? _____

Have you had any serious trouble associated with any previous dental treatment? Yes No

Please Explain: _____

I certify that I have read and understand the importance of disclosing my personal medical information on this health questionnaire and I have honestly provided the information to the best of my knowledge. I understand that misinformation given by me could be dangerous to my health and lead to inappropriate diagnosis and inappropriate dental treatment.

Patient or Guardian Signature _____ Date _____