Health History Form

Before filling out the health history form please read the following example of how important it is to give complete and accurate information.

A patient is taking birth control pills and does not tell her dentist because she is very young and her parents do not know. She gets an abscessed tooth and needs antibiotics. Antibiotics stop some forms of birth control from working and the patient gets pregnant without knowing why.

Patient's name:____ DOB:__________________________________

Do you have any allergies? If yes, please list: No:_____ Yes:_____

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Have you ever been to the hospital for anything other than child birth? No:______ Yes:_____
If yes, explain when and why:

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Do you have any chronic medical conditions? (High Blood Pressure, Hepatitis) No:_____ Yes: _____
If yes, please list:____
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Are you taking medication (prescription, over the counter, vitamins or supplements)? No:_____ Yes:_____
If yes, please list name, purpose for taking and dosage (amount and frequency of taking that amount):
Name: __________________________ Dosage: ______________ Purpose: ________________________________
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Name: __________________________ Dosage: ______________ Purpose: ________________________________

Who would you like us to contact in case of emergency? ____

Which of the following best describes you? 1-If my cleaning doesn't hurt a little, I don't feel like I was totally cleaned. 2-I like to get 100% clean as gentle as possible. Circle -1- or -2- .

Please answer yes/no to the following questions. If yes, please explain in space below:

- Have you had cancer radiological treatment of head/neck? No:_____ Yes:_____
- Have you taken bisphonates (esp Fosamax)? No:_____ Yes:_____
- Are you on birth control? No:_____ Yes:_____
- Are you pregnant or trying to get pregnant? No:_____ Yes:_____
- Have you had steroid or immunosuppressant therapy? No:_____ Yes:_____
- Are you on any antidepressants or anti-anxiety medications? No:_____ Yes:_____
- Have you ever had joint replacement surgery? No:_____ Yes:_____
- Do you need to pre-medicate with antibiotics? No:_____ Yes:_____
- Do you wear a pacemaker? No:_____ Yes:_____
    - If yes, is it shielded? No:_____ Yes:_____
    - If you do not know, was it placed after 1985? No:_____ Yes:_____
- Have they ever had an adverse reaction during a dental procedure? No:_____ Yes:_____

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Date of last dental cleaning: ___________________________ Date of last checkup xrays: ____________________

Have you ever had periodontal maintenance, a deep cleaning or had cleanings done more frequently than every 6 months in the past? No:____ Yes:____ If yes, how frequently? ____

Is there anything you would change about the appearance of your teeth or things you would primary like to accomplish with our office?____
____

Is there anything else you would like us to know about you, your teeth or your dental history?_________________
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____

I have reviewed the information on this page and it is accurate to the best of my knowledge. If there are any changes to my medical status, I will inform the office. I understand that the following are potential complications that can occur with any dental treatment, and although not common, they can occur to me: bruising or paresthesia (prolonged or permanent numbness) with anesthetic injections, TMJ (jaw bones and muscles) pain or problems from opening of the mouth for extended periods of time, soreness or swelling in and around the mouth from stretching and use of instruments, damage to adjacent teeth or prolonged sensitivity when work is done on any tooth, if cavities are larger than expected the price may increase and sometimes a root canal may be needed if cavity is larger than expected.

Signature (or initials and date of birth if done electronically):____

Name:____________________________________ **Date:**____

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