

Medical Alert:	Condition:	Premedication:	Allergies:	Anesthesia:	Date:
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HEALTH HISTORY FORM

Name: _____ Home Phone: () _____ Business 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? _____

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

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

MEDICAL INFORMATION

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

PLEASE COMPLETE BOTH SIDES