# HEALTH HISTORY QUESTIONNAIRE

Name: LAST FIRST MIDDLE Home Phone: ( )

Height: Weight: Date of Birth: Sex: M☐ F☐

Emergency Contact: Relationship: Phone: ( )

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

NAME RELATIONSHIP

## DENTAL HISTORY

Why did you come to our office?

Are you happy with your smile?

Is there anything about your mouth/smile that you would like to change?

How does coming to a dental office make you feel? (circle one) No anxiety / mild anxiety / moderate fear / very fearful

Have you ever been treated with any dental sedative (including laughing gas, sedative pills, IV sedation)? No☐ Yes☐

If yes what kind of sedative and how would you describe your experience?

Do you have any special concerns regarding your visit? Fear / Time / Money / Gagging / Other:

What is the main reason for you coming today?

When was your last dental visit?

Have you ever been treated for gum disease (Deep cleaning or Periodontal surgery)? No☐ Yes☐

Do you have any dental implants? No☐ Yes☐

Do you have sensitive teeth ? (circle each) Hot / Cold / Sweets / Pressure

Do you suffer from dry mouth? No☐ Yes☐

Do you get frequent headaches or migraines? No☐ Yes☐

Do you clench or grind your teeth? No☐ Yes☐

Do you have jaw clicking or popping? No☐ Yes☐

Do you get pain or soreness in the muscles of your head, face, or ear? No☐ Yes☐

Do you suffer from frequent earaches, sinus trouble? No☐ Yes☐

Have you ever had radiation treatment to your head or neck? No☐ Yes☐

Do your gums bleed when you brush or floss? No☐ Yes☐

## MEDICAL HISTORY

If you have now, or have had any of the following problems in the past, please (x) yes. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

| | | | |
|---|---|---|---|
| Heart Murmur ( including mitral valve prolapse) | No☐ Yes☐ | HIV Positive or AIDS Related Complex | No☐ Yes☐ |
| Heart Disease (including surgery or heart attack) | No☐ Yes☐ | Emphysema or other Respiratory Illnesses | No☐ Yes☐ |
| Heart Arrhythmia/Heart Pacemaker | No☐ Yes☐ | Asthma | No☐ Yes☐ |
| Rheumatic Fever | No☐ Yes☐ | High/Low Blood Pressure | No☐ Yes☐ |
| Liver Disease (including Jaundice) | No☐ Yes☐ | Diabetes (Type I or II) | No☐ Yes☐ |
| Hepatitis, Any Form | No☐ Yes☐ | Thyroid Problems | No☐ Yes☐ |
| Kidney Disease | No☐ Yes☐ | Joint Replacement Surgery | No☐ Yes☐ |
| Tuberculosis | No☐ Yes☐ | Glaucoma | No☐ Yes☐ |
| Stroke | No☐ Yes☐ | Epilepsy | No☐ Yes☐ |
| Arthritis / Rheumatism | No☐ Yes☐ | Nervous or mental disorder | No☐ Yes☐ |
| Abnormal Bleeding | No☐ Yes☐ | Unintentional Weight Loss / Gain | No☐ Yes☐ |
| Anemia or other blood disease | No☐ Yes☐ | Stomach Trouble ( Ulcers, GERD, etc.) | No☐ Yes☐ |
| Venereal Disease (syphilis, Herpes, etc.) | No☐ Yes☐ | Drug or Alcohol Dependency | No☐ Yes☐ |
| Recurrent or Unusual Infections | No☐ Yes☐ | Recurrent Illnesses | No☐ Yes☐ |

Please list any other medical condition(s) or problem(s) not listed above. Please list any other health concerns or special issues that you would like to discuss with the doctor:

PLEASE COMPLETE BOTH SIDES

# HEALTH HISTORY QUESTIONNAIRE (CONTINUED)

Have you been hospitalized or had any operation within the last five years? No☐ Yes☐

Please list: _____

Are you required to Pre-Medicate (with antibiotics) before dental treatment? No☐ Yes☐

If yes, please list the reason: _____

Do you take any blood thinners (Coumadin, Plavix, Daily Aspirin)? No☐ Yes☐

List all medications you are taking and the reason for taking them: _____

Do you take (or have you ever taken) any of the following medications?

Bisphosphonate drugs such as Fosamax, Zometa, Boniva, Actonel No☐ Yes☐

Antacids including Tagamet (Cimetidine) No☐ Yes☐

Diet Drugs (Pondimin, Redux, Phen-Fen) No☐ Yes☐

Are you allergic to any medications (including Penicillin, Aspirin, Codiene, Sulfa Drugs)? No☐ Yes☐

If yes, please list: _____

Do you have any other allergies (including metals, latex, food allergy)? No☐ Yes☐

If yes, please list: _____

Do you smoke? No☐ Yes☐

If yes, how many packs a day? For how many years? _____

**WOMEN ONLY**

Are you pregnant or is there a chance that you are pregnant? No☐ Yes☐

If no, are you planning a pregnancy in the near future? No☐ Yes☐

Are you a nursing mother? No☐ Yes☐

**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. 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.

SIGNATURE OF PATIENT/LEGAL GUARDIAN _____ DATE _____

Reviewed Health Hx

DOCTOR _____ DATE _____

DATE: _____

CHANGES: _____

SIGNATURE OF PATIENT

SIGNATURE OF DOCTOR

DATE: _____

CHANGES: _____

SIGNATURE OF PATIENT

SIGNATURE OF DOCTOR

DATE: _____

CHANGES: _____

SIGNATURE OF PATIENT

SIGNATURE OF DOCTOR