# Confidential Health History

Patient Name: _____ Date of Birth: _____

**I. CIRCLE APPROPRIATE ANSWER** (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
   If NO, explain: _____
2. Yes / No Has there been a change in your health within the last year?
   If YES, explain: _____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: _____
4. Yes / No Are you being treated by a physician now? If YES, explain: _____
   Date of last medical exam? _____ Reason for exam: _____
5. Yes / No Have you had problems with prior dental treatment?
   If YES, explain: _____
   Date of last dental exam: _____ Name of last treating dentist: _____
6. Yes / No Are you in pain now?
   If YES, explain: _____

**II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING?** (Please circle Yes or No for each)

| | | | | | |
|---|---|---|---|---|---|
| Yes / No | Chest pain (angina) | Yes / No | Blood in stools | Yes / No | Frequent vomiting |
| Yes / No | Fainting spells | Yes / No | Diarrhea or constipation | Yes / No | Jaundice |
| Yes / No | Recent significant weight loss | Yes / No | Frequent urination | Yes / No | Dry mouth |
| Yes / No | Fever | Yes / No | Difficulty urinating | Yes / No | Excessive thirst |
| Yes / No | Night sweats | Yes / No | Ringing in ears | Yes / No | Difficulty swallowing |
| Yes / No | Persistent cough | Yes / No | Headaches | Yes / No | Swollen ankles |
| Yes / No | Coughing up blood | Yes / No | Dizziness | Yes / No | Joint pain or stiffness |
| Yes / No | Bleeding problems | Yes / No | Blurred vision | Yes / No | Shortness of breath |
| Yes / No | Blood in urine | Yes / No | Bruise easily | Yes / No | Sinus problems |

Other: _____

**III. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING?** (Please circle Yes or No for each)

| | | | | | |
|---|---|---|---|---|---|
| Yes / No | Heart disease | Yes / No | AIDS/HIV | Yes / No | Psychiatric care |
| Yes / No | Family history of heart disease | Yes / No | Surgeries | Yes / No | Osteoporosis |
| Yes / No | Heart attack | Yes / No | Hospitalization | Yes / No | Thyroid disease |
| Yes / No | Artificial joint | Yes / No | Diabetes | Yes / No | Asthma |
| Yes / No | Stomach problems or ulcers | Yes / No | Family history of diabetes | Yes / No | Hepatitis |
| Yes / No | Heart defects | Yes / No | Tumors or cancer | Yes / No | Sexual transmitted disease |
| Yes / No | Heart murmurs | Yes / No | Chemotherapy | Yes / No | Herpes |
| Yes / No | Rheumatic fever | Yes / No | Radiation | Yes / No | Canker or cold sores |
| Yes / No | Skin disease | Yes / No | Arthritis, rheumatism | Yes / No | Anemia |
| Yes / No | Hardening of arteries | Yes / No | Emphysema or other lung disease | Yes / No | Liver disease |
| Yes / No | High blood pressure | Yes / No | Kidney or bladder disease | Yes / No | Eye disease |
| Yes / No | Seizures | Yes / No | Stroke | Yes / No | Transplants |
| Yes / No | Cosmetic surgery | Yes / No | Eating disorders | Yes / No | Tuberculosis |

Other: _____

**IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?**
(Please circle Yes or No for each)

| | | | | | |
|---|---|---|---|---|---|
| Yes / No | Aspirin | Yes / No | Valium or other sedatives | Yes / No | Codeine or other narcotics |
| Yes / No | Penicillin or other antibiotics | Yes / No | Latex | Yes / No | Food |
| Yes / No | Nitrous oxide | Yes / No | Local anesthetic | Yes / No | Metal |

Others: _____

**V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?**
(Please circle Yes or No for each)

| | | | | | |
|---|---|---|---|---|---|
| Yes / No | Recreational drugs | Yes / No | Tobacco in any form | Yes / No | Antibiotics |
| Yes / No | Over-the-counter medicines | Yes / No | Alcohol | Yes / No | Supplements |
| Yes / No | Weight loss medications | Yes / No | Bisphosphonate (Fosamax) | Yes / No | Aspirin |
| Yes / No | Anti-Depressants | Yes / No | Herbal Supplements | | |

Please list all prescription medications: _____

**VI. WOMEN ONLY** (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, what month? _____
Yes / No Are you nursing?
Yes / No Are you taking birth control pills?

**VII. ALL PATIENTS** (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: _____

Yes / No Have you ever taken Fen-Phen? If YES, when: _____

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

*The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.*

*I authorize the dentist to contact my physician.*

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

**Whom would you like us to contact in case of an emergency?**

**Name**: _____ **Relationship**: _____ **Phone Number**: _____

**I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.**

_____ _____ _____ _____
Signature of Patient (Parent or Guardian) Date Signature of Dentist Date

# Dental History Form

Patient Name: _____ Date of Birth: _____

Date of Last Dental Visit? _____/_____/_____ Reason for the Visit? _____

Date of Last Dental X-rays? _____/_____/_____

Former Dentist: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

If you left your previous dentist, what was the reason? _____

What are your goals in coming to our practice today? _____

What is important to you in a dentist or dental practice? _____

## At-Home Oral Hygiene Care

How often do you brush your teeth? _____

How often do you floss? _____

Do you use mouthwash? Yes/No

If YES, which kind: _____

Do you use any other dental home care products? Yes/No

If YES, which kind: _____

**Circle Appropriate Answer** (Leave blank if you do not understand the questions)

1. Are you currently experiencing dental pain or discomfort? Yes/No
   If YES, explain: _____

2. Do your gums bleed? Yes/No
   If YES, explain: _____

3. Are your teeth loose? Yes/No
   If YES, explain: _____

4. Do you wear dentures or partials? Yes/No
   If YES, explain: _____

5. Have you ever been told you have gum disease? Yes/No
   If YES, explain: _____

6. Are your teeth sensitive to hot, cold, sweets or pressure? Yes/No
   If YES, explain: _____

7. Have your ever had any clicking, popping or discomfort in the jaw? Yes/No
   If YES, explain: _____

8. Do you brux or grind your teeth? Yes/No
   If YES, explain: _____

9. Do you wear an occlusal guard? Yes/No

10. Have you ever had orthodontic treatment (braces) before? Yes/No
    If YES, explain: _____

11. Do you have dry mouth? Yes/No
    If YES, explain: _____

12. Does food or floss catch between your teeth? Yes/No
    If YES, explain: _____

13. Have you had any problems or an upsetting dental experience associated with previous dental care? Yes/No
    If YES, explain: _____

14. Are you fearful of dentistry or have anxiety associated with dental treatment? Yes/No
    If YES, explain: _____

15. Have you ever been pre-medicated for dental treatment? Yes/No
    If YES, explain: _____

16. Have you ever had a reaction to anesthetic used with your dental treatment? Yes/No
    If YES, explain: _____

17. Are you happy with your smile? Yes/No
    If NO, please explain: _____

18. What would you change about the present condition of your mouth? _____
    _____

19. Is there anything else you would like us to know about your dental health or dental history? Yes/No
    If YES, explain: _____

**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 dental 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 inquiries set forth above have been answered to my satisfaction.**

_____ _____

**Signature of Patient (Parent or Guardian)** **Date**

_____ _____

**Signature of Dentist** **Date**

(6/2015)