HEALTH HISTORY FORM

PRIME Dental

E-mail: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be other 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.

Name: Home Phone: *Include area code* Business/Cell Phone: *Include area code*

Last First Middle ( ) ( )

Address: City: State: Zip:

Mailing address

Occupation: Height: Weight: Date of birth: / / Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: Cell Phone:

( ) ( )

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

Your Name Relationship

Do you have any of the following diseases or problems: ***(Check DK if you Don't Know the answer to the question)***

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information

For the following questions, please mark (X) your responses to the following questions

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:_____

What was done at that time?_____

_____

Date of last dental x-rays:_____

What is the reason for your dental visit today?_____

_____

How do you feel about your smile? Are there anything you would like to change or improve in your smile? _____

_____

Medical Information

For the following questions, please mark (X) your responses to the following questions.

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code*

_____ ( ) _____

Address/City/State/Zip:

_____

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?_____

_____

Date of last physical exam _____/_____/_____

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?_____

_____

_____

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:_____

_____

_____

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question) **Yes No DK**

Do you wear contact lenses? ☐ ☐ ☐

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ ☐ ☐
Date: ____/___/___ If yes, have you had any complications?_____

Are you taking or scheduled to begin taking either of the medications alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? ☐ ☐ ☐

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain , hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐ ☐
Date Treatment began: _____

Yes No DK

Do you use controlled substances (drugs)? ☐ ☐ ☐

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ ☐ ☐
If so, how interested are you in stopping?
(Circle one) VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? ☐ ☐ ☐
If yes, how much alcohol did you drink in the last 24 hours? _____
If yes, how much do you typically drink In a week? _____

WOMEN ONLY Are you:
Pregnant? ☐ ☐ ☐
Number of weeks: _____
Taking birth control pills or hormonal replacement? ☐ ☐ ☐
Nursing? ☐ ☐ ☐

Allergies - Are you allergic to or have you had a reaction to: **Yes No DK**
To all **yes** responses, specify type of reaction.

Local anesthetics_____ ☐ ☐ ☐
Aspirin _____ ☐ ☐ ☐
Penicillin or other antibiotics _____ ☐ ☐ ☐
Barbiturates, sedatives, or sleeping pills _____. ☐ ☐ ☐
Sulfa drugs _____ ☐ ☐ ☐
Codeine or other narcotics _____ ☐ ☐ ☐

Yes No DK

Metals_____. ☐ ☐ ☐
Latex (rubber) _____. ☐ ☐ ☐
Iodine _____ ☐ ☐ ☐
Hay fever/seasonal _____ ☐ ☐ ☐
Animals_____ ☐ ☐ ☐
Food _____ ☐ ☐ ☐
Other _____ ☐ ☐ ☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Yes No DK

Artificial (prosthetic) heart valve ☐ ☐ ☐
Previous infective endocarditis ☐ ☐ ☐
Damaged valves in transplanted heart ☐ ☐ ☐
Congenital heart disease (CHD):
Unrepaired, cyanotic CHD ☐ ☐ ☐
Repaired (completely) in last 6 months ☐ ☐ ☐
Repaired CHD with residual defects ☐ ☐ ☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Yes No DK

Severe or rapid weight loss ☐ ☐ ☐
Cardiovascular disease. ☐ ☐ ☐
Angina ☐ ☐ ☐
Arteriosclerosis ☐ ☐ ☐
Congestive heart failure ☐ ☐ ☐
Damaged heart valves ☐ ☐ ☐
Heart attack ☐ ☐ ☐
Heart murmur ☐ ☐ ☐
Low blood pressure ☐ ☐ ☐
High blood pressure ☐ ☐ ☐
Other congenital heart defects ☐ ☐ ☐

Yes No DK

Mitral valve prolapse ☐ ☐ ☐
Pacemaker ☐ ☐ ☐
Rheumatic fever ☐ ☐ ☐
Rheumatic heart disease ☐ ☐ ☐
Abnormal bleeding ☐ ☐ ☐
Anemia ☐ ☐ ☐
Blood transfusion ☐ ☐ ☐
If yes, date:_____/_____/_____
Hemophilia ☐ ☐ ☐
STD ☐ ☐ ☐

Yes No DK

Autoimmune disease ☐ ☐ ☐
Rheumatoid arthritis ☐ ☐ ☐
Systemic lupus erythematosus ☐ ☐ ☐
Fainting spells or seizures ☐ ☐ ☐
Neurological disorders ☐ ☐ ☐
Emphysema ☐ ☐ ☐
Sinus trouble ☐ ☐ ☐
Mental health disorders ☐ ☐ ☐
Cancer/Chemotherapy/
Radiation Treatment ☐ ☐ ☐
Chest pain upon exertion ☐ ☐ ☐
Chronic pain ☐ ☐ ☐
Diabetes Type I or II ☐ ☐ ☐
Eating disorder ☐ ☐ ☐
Malnutrition ☐ ☐ ☐
Gastrointestinal disease ☐ ☐ ☐
G.E. Reflux/persistent
heartburn ☐ ☐ ☐
Ulcers ☐ ☐ ☐
Thyroid problems ☐ ☐ ☐
Stroke ☐ ☐ ☐
AIDS or HIV infection ☐ ☐ ☐

Yes No DK

Hepatitis, jaundice or
liver disease ☐ ☐ ☐
Epilepsy ☐ ☐ ☐
Asthma ☐ ☐ ☐
Bronchitis ☐ ☐ ☐
If yes, specify:_____
Sleep disorder ☐ ☐ ☐
Tuberculosis ☐ ☐ ☐
Recurrent Infections ☐ ☐ ☐
Type of infection:_____
Kidney problems ☐ ☐ ☐
Night sweats ☐ ☐ ☐
Osteoporosis ☐ ☐ ☐
Persistent swollen glands
in neck ☐ ☐ ☐
Severe headaches/
migraines ☐ ☐ ☐
Arthritis ☐ ☐ ☐
Glaucoma ☐ ☐ ☐
Excessive urination ☐ ☐ ☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐
Name of physician or dentist making recommendation: _____ Phone:_____
Do you have any disease, condition, or problem not listed above that you think we should know about? ☐ ☐ ☐
Please 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 health 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. 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:**