Media Center Dental - Health History Form

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 additional questions concerning your health. Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. This office does not use this information to discriminate. Thank you for answering the following questions.

Today's Date:

First and Last Name:		Home Phone: ( )		Business/Cell Phone: ( )
Address:		City:	State:	Zip:
Occupation:	Height:	Weight:	Date of Birth:	Sex: M or F
SS# or Patient ID:		E-Mail:		
Emergency Contact:	Relationship:	Home Phone: ( )	Cell Phone: ( )	
If you are completing this form for another person, what is your relationship to that person?				

Do you have any of the following diseases or problems:

	Yes	No	Don't Know
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answered 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	Don't Know
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 problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
If yes, how often? Circle one: DAILY/WEEKLY/OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	Don't Know
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?
What is the reason for your dental visit today?	
How do you feel about your smile?	

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

	Yes	No	Don't Know
Are you now under the care of a physician?	☐	☐	☐
Physician Name: Phone Number: ( )			
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	Don't Know
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: _____			

	Yes	No	Don't Know
Do you wear contact lenses?	☐	☐	☐
Are you taking, or have taken any diet drugs such as Pondimin (fenflluramine), Redux (desphenfluramine) or phen-fen (fenflluramine-phentermine combination)?	☐	☐	☐
Have you ever taken, are taking or is scheduled to begin taking either of the medication, alendronate (Fosamax®), risedronate (Actonel®), Bonivia, or any other medication containing bisphosphonates 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 mestastic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	Don't Know
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			
Are you on a special diet?			
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: _____			
Trying to get pregnant?	☐	☐	☐
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

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

Allergies. Are you allergic to or have you had a reaction to:

	Yes	No	Don't Know	(to all **yes** responses, specify type of reaction)
Local anesthetics	☐	☐	☐	_____
Aspirin	☐	☐	☐	_____
Penicillin or other antibiotics	☐	☐	☐	_____
Vicodin	☐	☐	☐	_____
Babitatures, sedatives or sleeping pills	☐	☐	☐	_____
Sulfa drugs	☐	☐	☐	_____
Codeine or other narcotics	☐	☐	☐	_____
Metals	☐	☐	☐	_____
Latex (rubber)	☐	☐	☐	_____
Acrylic	☐	☐	☐	_____
Iodine	☐	☐	☐	_____
Hay fever/seasonal	☐	☐	☐	_____
Animals	☐	☐	☐	_____
Food	☐	☐	☐	_____
Darvon	☐	☐	☐	_____
Valium	☐	☐	☐	_____
Demerol	☐	☐	☐	_____
Erythromycin	☐	☐	☐	_____

Tetracycline	☐	☐	☐	_____
Percodan	☐	☐	☐	_____
Nitrous oxide	☐	☐	☐	_____

Other (please specify)_____

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

	Yes	No	Don't Know		Yes	No	Don't Know
Heart murmur	☐	☐	☐	Mitral valve prolapse	☐	☐	☐
Artificial heart valves	☐	☐	☐	Rheumatic fever	☐	☐	☐
Cardiovascular disease	☐	☐	☐	Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐	Congestive heart failure	☐	☐	☐
Coronary artery disease	☐	☐	☐	Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐	Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐	Congenital heart defects	☐	☐	☐
Pacemaker	☐	☐	☐	Rheumatic heart disease	☐	☐	☐
Abnormal/excessive bleeding	☐	☐	☐	Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐	Hemophilia	☐	☐	☐
If yes, date: _____				Aids/HIV infection	☐	☐	☐
Arthritis	☐	☐	☐	Gout	☐	☐	☐
Autoimmune disease	☐	☐	☐	Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐	Asthma	☐	☐	☐
Bronchitis	☐	☐	☐	Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐	Tuberculosis	☐	☐	☐
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 disease/problems	☐	☐	☐
Stroke	☐	☐	☐	Glaucoma	☐	☐	☐
Hepatitis A	☐	☐	☐	Hepatitis B or C	☐	☐	☐
Jaundice or liver disease	☐	☐	☐	Epilepsy	☐	☐	☐
Fainting spells/seizures/dizziness	☐	☐	☐	Neurological disorders	☐	☐	☐
				If yes, specify: _____			
Sleep Disorders	☐	☐	☐	Tonsillitis	☐	☐	☐
Mental health disorders	☐	☐	☐	Recurrent infections	☐	☐	☐
Specify: _____				Type of infection: _____			
Kidney problems	☐	☐	☐	Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐	Persistent swollen glands in neck	☐	☐	☐
Severe headaches/migraines	☐	☐	☐	Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐	Excessive urination	☐	☐	☐
Alzheimer's disease	☐	☐	☐	Anaphylaxis	☐	☐	☐
Artificial joint	☐	☐	☐	Blood disease	☐	☐	☐
Breathing problems	☐	☐	☐	Bruise easily	☐	☐	☐
Cold sores/fever blisters	☐	☐	☐	Convulsions	☐	☐	☐
Cortisone medicine	☐	☐	☐	Drug addiction	☐	☐	☐
Easily winded	☐	☐	☐	Excessive thirst	☐	☐	☐
Fainting spells/dizziness	☐	☐	☐	Frequent cough	☐	☐	☐
Frequent diarrhea	☐	☐	☐	Frequent headaches	☐	☐	☐
Genital herpes	☐	☐	☐	Hay fever	☐	☐	☐
Heart trouble/disease	☐	☐	☐	Herpes	☐	☐	☐
High cholesterol	☐	☐	☐	Hives or rash	☐	☐	☐
Hypoglycemia	☐	☐	☐	Irregular heartbeat	☐	☐	☐
Leukemia	☐	☐	☐	Lung disease	☐	☐	☐
Pain in jaw joints	☐	☐	☐	Parathyroid disease	☐	☐	☐
Psychiatric care	☐	☐	☐	Renal dialysis	☐	☐	☐
Rheumatism	☐	☐	☐	Scarlet fever	☐	☐	☐
Shingles	☐	☐	☐	Sickle cell disease	☐	☐	☐
Spina bifida	☐	☐	☐	Stomach/intestinal disease	☐	☐	☐
Swelling of limbs	☐	☐	☐	Venereal disease	☐	☐	☐
Tumors or growths	☐	☐	☐				
Yellow jaundice	☐	☐	☐				

Have you ever had any serious illness not listed above? _____

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 I should know about? Please explain:	

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 and that information given on his 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 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.
To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient/Legal Guardian:	Date:

For Completion by Dentist

Comments:_____
_____
_____
_____
_____
_____