CONFIDENTIAL HEALTH & DENTAL HISTORY FORM

Today's Date _____/_____/_____

Patient Name: First _____ MI _____ Last _____ Date of Birth _____/_____/_____

MEDICAL HISTORY *(Check appropriate answer)*

Yes No

☐ ☐ Is patient in good health?
If NO, explain _____

☐ ☐ Has there been a change in the patient's health within the last year?
If YES, explain _____

☐ ☐ Has the patient ever been hospitalized or had any major operations?
If YES, for what reason and when _____

☐ ☐ Is patient under a physician's care now?
If YES, explain _____

Date of last medical exam _____/_____/_____ If patient is a child, is immunization up to date? ☐ YES ☐ No

☐ ☐ Have the patient had problems with prior dental treatment?
If YES, explain _____

Date of last dental exam _____/_____/_____ Name of last treating dentist _____

☐ ☐ Has the patient ever had general anesthesia?
If YES, for what reason and were there any complications _____

☐ ☐ Is patient in pain now?
If YES, explain _____

Has the patient experienced, have or had any of the following? *(Please check Yes or No for each)*

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Alzheimer's Disease	☐	☐	Anaphylaxis	☐	☐	Anemia	☐	☐	Arthritis/Gout/Rheumatism
☐	☐	Artificial Heart Valve	☐	☐	Artificial Joint	☐	☐	Asthma	☐	☐	Blood Disease
☐	☐	Blood Transfusion	☐	☐	Blurred Vision	☐	☐	Bruise Easily	☐	☐	Cancer or Tumors
☐	☐	Canker or Cold Sores	☐	☐	Chemotherapy	☐	☐	Chest Pain/Angina	☐	☐	Cosmetic Surgery
☐	☐	Coughing up blood	☐	☐	Diabetes	☐	☐	Difficulty Swallowing	☐	☐	Dry Mouth
☐	☐	Drug Addiction	☐	☐	Eating Disorders	☐	☐	Eye Disease	☐	☐	Emphysema
☐	☐	Excessive Bleeding	☐	☐	Excessive Thirst	☐	☐	Fainting Spells/Dizziness	☐	☐	Frequent Cough
☐	☐	Frequent Diarrhea	☐	☐	Frequent Headaches	☐	☐	Frequent Vomiting	☐	☐	Gastric/Acid Reflux
☐	☐	Heart Attack/Failure	☐	☐	Heart Disease/Defects	☐	☐	Heart Murmur	☐	☐	Hepatitis
☐	☐	Herpes	☐	☐	High Blood Pressure	☐	☐	Hypoglycemia	☐	☐	Jaundice
☐	☐	Kidney/Bladder Disease	☐	☐	Liver Disease	☐	☐	Lung Disease	☐	☐	Osteoporosis
☐	☐	Radiation Treatments	☐	☐	Rheumatic Fever	☐	☐	Seizures or Epilepsy	☐	☐	Shortness of Breath
☐	☐	Sinus Problems	☐	☐	Sleep Apnea	☐	☐	Stomach Problems/Ulcers	☐	☐	Stroke
☐	☐	Swelling of Limbs	☐	☐	Thyroid Disease	☐	☐	Transplants	☐	☐	Tuberculosis

This information will not be released unless specifically authorized by patient. *(Please check Yes or No for each)*

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	AIDS/HIV	☐	☐	Anxiety	☐	☐	Depression	☐	☐	Treatment for emotional, mental, or physical delays

Are you allergic to or have you had a reaction to any of the following? *(Please check Yes or No for each)*

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Aspirin	☐	☐	Codeine	☐	☐	Acrylic	☐	☐	Valium
☐	☐	Penicillin	☐	☐	Vicodin	☐	☐	Metal	☐	☐	Versed
☐	☐	Erythromicin	☐	☐	Darvon	☐	☐	Nitrous Oxide	☐	☐	Demerol
☐	☐	Tetracycline	☐	☐	Percodan	☐	☐	Food	☐	☐	Latex
☐	☐	Local Anesthetic	☐	☐	Other _____						

Is the patient taking or has taken any of the following in the last three months? *(Please check Yes or No for each)*

Yes	No		Yes	No		Yes	No	
☐	☐	Recreational Drugs	☐	☐	Tobacco in any form	☐	☐	Antibiotics
☐	☐	Over-the-counter medicines	☐	☐	Alcohol	☐	☐	Supplements
☐	☐	Weight loss medications	☐	☐	Bisphosphonate (Fosamax)	☐	☐	Aspirin
☐	☐	Cortico-Steroids						

List of current medications _____

_____

Women only *(Please check Yes or No for each)*

Yes	No	
☐	☐	Is there a possibility that you may be pregnant? If YES, what month? _____
☐	☐	Are you nursing?
☐	☐	Are you taking birth control pills?

All patients *(Please check Yes or No for each)*

Yes	No	
☐	☐	Does the patient have or has had any other diseases or medical conditions NOT listed on this form? If YES, explain _____
☐	☐	Has the patient ever been pre-medicated for dental treatment? If YES, why _____
☐	☐	Has the patient ever taken Fen-Phen? If YES, when _____
☐	☐	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 the patient's physician:

Patient/Guardian Signature _____ Date _____

Physician's Name _____ Phone # _____

DENTAL HEALTH/HISTORY

What concerns does the patient currently have with his/her oral health or smile? *(Please check Yes or No for each)*

Yes	No		Yes	No		Yes	No	
☐	☐	Bad Breath	☐	☐	Clenching/Grinding of Teeth	☐	☐	Crowding/Crooked Teeth
☐	☐	Difficulty Chewing	☐	☐	Discolored Teeth	☐	☐	Habits (Thumb sucking, cheek biting, etc.)
☐	☐	Injury to face, mouth, or teeth	☐	☐	Jaw Joint Pain	☐	☐	Loose Tooth/Teeth
☐	☐	Missing/Extra Teeth	☐	☐	Mouth breathing, snoring	☐	☐	Old Fillings (gold or silver)
☐	☐	Old Crowns	☐	☐	Overbite/Underbite	☐	☐	Sensitivity to hot/cold or anything else
☐	☐	Spaces in between teeth	☐	☐	Speech Problems	☐	☐	Too much gum tissue when I smile
☐	☐	Tooth Ache/Pain	☐	☐	Tooth shape or size	☐	☐	Uncomfortable Bite

Have the patient ever had orthodontic treatment? ☐ YES ☐ NO If YES, when? _____

Have the patient ever had periodontal (gum tissue) treatment, such as deep cleanings, root planning, or periodontal surgery?

☐ YES ☐ NO If YES, when? _____

Has the patient whitened his/her teeth in the past? ☐ YES ☐ NO If YES, what method? _____

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 the dentist of any change in my/my child's health and/or medication. Further, I will not hold the 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 or Guardian _____ Date_____

Signature of Dentist _____ Date _____