HEALTH HISTORY FORM

Patient Name: _____ Birth Date: ___/___/_____
Address: _____ City:_____
State: _____ Zip: _____ Phone Number: _____
Email: _____ SS#:_____

If you are completing this form for another person, what is your relationship?
Name: _____ Relationship: _____
Phone number: _____ Email: _____

Dental information *Please circle Y for "yes" or N for "no"*

Y/N Is your mouth dry?
Y/N Do you wear dentures or partials?
Y/N Are any of your teeth sensitive to hot/cold/sweets or pressure?
Y/N Have you had any problems associated with previous dental treatment?
Y/N Do you have any clicking, popping or discomfort in the jaw?
Y/N Do you have a history of persistent acid reflux or heartburn?
Y/N Are you currently experiencing dental pain or discomfort?
Y/N Do you snore or have you been diagnosed with sleep apnea?

Medical information

Physician Name: _____ Phone: _____
Address: _____ City: _____
State: _____ Zip: _____

Do you need to take premedication prior to dental treatment? Y/N
Reason: _____
Pharmacy Name:_____ Phone Number:_____

Please list all medications *including prescribed, OTC, vitamins and supplements*

_____ _____
_____ _____
_____ _____
_____ _____

Do you have any allergies to the following? *Please circle Y for "yes" or N for "no"*

Y/N Local anesthetics
Y/N Penicillin or other antibiotics
Y/N Codeine or other narcotics
Y/N Latex (rubber)
Y/N Hay fever/seasonal
Y/N Food
Y/N Aspirin
Y/N Iodine
Y/N Animals
Y/N Metals
Y/N Sulfa drugs
Y/N Other: _____

Joint Replacement

Y/N Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

Type:_____ Date(s): _____

Please indicate if you HAVE or HAD any of the following:

Y/N	Abnormal bleeding	Y/N	Heart murmur
Y/N	AIDS or HIV infection	Y/N	Hepatitis, jaundice or liver disease
Y/N	Anemia	Y/N	Hemophilia
Y/N	Angina	Y/N	High blood pressure
Y/N	Arteriosclerosis	Y/N	Low blood pressure
Y/N	Arthritis	Y/N	Mitral valve prolapse
Y/N	Asthma	Y/N	Other congenital heart defect
Y/N	Autoimmune disease	Y/N	Pacemaker
Y/N	Bronchitis	Y/N	Rheumatic fever
Y/N	Cancer/Chemotherapy/ Radiation Treatment	Y/N	Rheumatic heart disease
Y/N	Congestive heart failure	Y/N	Sinus trouble
Y/N	Cardiovascular disease	Y/N	Stroke
Y/N	Damaged heart valves	Y/N	Sleep disorder
Y/N	Diabetes Type I or II	Y/N	Severe headaches/ migraines
Y/N	Emphysema	Y/N	Severe or rapid weight loss
Y/N	Epilepsy	Y/N	Sexually transmitted disease
Y/N	Glaucoma	Y/N	Tuberculosis
Y/N	Heart attack	Y/N	Thyroid problems

NOTE: Both the dental hygienist 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 the information given on this form is accurate. I understand the importance of a truthful health history and that my dental hygienist 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 dental hygienist 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.

Date: _____ Signature of Patient/Legal Guardian:_____

Date: _____ Signature of Dental Hygienist:_____