Health History

holland family dentistry

Name _____
Last First Middle

Address: _____
Street Name City State Zip Code

(_____) _____
Phone Number E-Mail SSN Date of Birth

_____
Emergency Contact Relationship Phone Number

Dental Information For the following questions, please circle your responses to the following questions

Do your gums bleed when you brush or floss? --------- YES NO
Are your teeth sensitive to cold? ---------- YES NO
Is your Mouth Dry? ---------- YES NO
Have you had any periodontal (gum) treatments? ---- YES NO
Have you ever had orthodontic (braces)
Treatments? ---------- YES NO
Have you had any problems associated with
Dental treatment? ----------YES NO
Is your home water supply fluoridated? ---------- YES NO
What is the reason for your dental visit today? -------- YES NO
How do you feel about your smile?
_____

Do you have earaches or neck pains? ---------- YES NO
Do you have any clicking, popping, or
discomfort in the jaw? ---------- YES NO
Do you brux or grind your teeth? ---------- YES NO
Do you have sores or ulcers in your mouth? ------ YES NO
Do you wear dentures or partials? ---------- YES NO
Do you participate in active recreational
activities? ---------- YES NO
Have you ever had a serious injury to your head
or mouth? ---------- YES NO
Date of your last dental exam: _____
What was done at that time: _____
Date of last dental x-rays: _____

Medical Information Please circle your response to indicate if you have or have not had any of the following diseases or problems

Are you now under the care of a physician? ---------- YES NO
Physician Name: _____
Are you in good health? ---------- YES NO
Has there been any change in your general
Health within the past year? ---------- YES NO
Joint Replacement Have you had an orthopedic
Total joint (hip, knee, elbow, finger) replacement? ----YES NO
Date:_____ if yes, have you had any complications? YES NO
Are you taking or scheduled to begin taking either of
the medications, alendronate (Fosamax) or
risedronate (Actonel) for osteoporosis or
Paget's disease? ---------- YES NO
Since 2001, were you treated or are you presently
Scheduled to begin treatment with the intravenous
Bisphosphorates (Aredia or Zometa) for bone pain,
Hypercalcemia or skeletal complications resulting
From Paget's disease, multiple myeloma or
Metastatic cancer? ---------- YES NO
Date Treatment began: _____

Are you taking or have you recently taken any prescriptions
or over the counter medicines? ---------- YES NO
If so, please list all, including vitamins, natural or herbal
preparations and/or diet supplements: _____
_____
_____
_____

Do you use controlled substances (drugs)? -------- YES NO
Do you use tobacco (smoking,snuff,chew,bidis)? YES NO
If so, how interested are you in stopping? (Circle one)
VERY SOMEWHAT NOT INTERESTED
Do you drink alcoholic beverages? ---------- YES NO
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? YES NO if yes, Number of weeks _____
Taking Birth Control or Hormone replacement? YES NO
Nursing? ---------- YES NO

Medical Information Please circle your response to indicate if you have or have not had any of the following diseases or problems

Allergies Are you allergic to or have you had a reaction to: (To all yes responses, specify type of reaction)

Local anesthetics ---------- YES NO
Aspirin ---------- YES NO
Penicillin or other antibiotics ---------- YES NO
Barbiturates, sedatives, or sleeping pills --- YES NO
Sulfa Drugs ---------- YES NO
Codeine or other narcotics ---------- YES NO

Metals ---------- YES NO
Latex (Rubber) ---------- YES NO
Iodine ---------- YES NO
Hay Fever/seasonal ---------- YES NO
Animals ---------- YES NO
Food ---------- YES NO
Other ---------- YES NO

Please circle your response to indicate if you have of have not had any of the following diseases or problems.

Artificial (prosthetic) heart valve ---------- YES NO
Previous infective endocarditis ---------- YES NO
Damaged valves in transplanted heart ------YES NO
Congenital heart disease (CHD) ----------YES NO
Unrepaired, cyariotic CHD ----------YES NO
Repaired (completely) in last 6 months YES NO
Repaired CHD with residual defects -----YES NO
Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD

Cardiovascular Disease ---------- YES NO
Angina ---------- YES NO
Arteriosclerosis ---------- YES NO
Congestive Heart Failure ---------- YES NO
Heart Attack ---------- YES NO
Heart Murmur ---------- YES NO
Low Blood Pressure ---------- YES NO
Other Congenital Heart Defects ---------- YES NO
Mitral Valve prolapse ---------- YES NO
Pacemaker ---------- YES NO
Rheumatic Fever ---------- YES NO
Rheumatic Heart Disease ---------- YES NO
Abnormal Bleeding ---------- YES NO
Hemophilia ---------- YES NO

Auto immune disease ---------- YES NO
Asthma ---------- YES NO
Tuberculosis ---------- YES NO
Cancer/Chemo/Radiation treatment ---------- YES NO
Chronic Pain ---------- YES NO
Diabetes Type I or II ---------- YES NO
Eating Disorder ---------- YES NO
Gastrointestinal disease ---------- YES NO
Ulcers ---------- YES NO
Thyroid problems ---------- YES NO
Stroke ---------- YES NO
Hepatitis, jaundice or liver disease ---------- YES NO
Epilepsy ---------- YES NO
Fainting spells or seizures---------- YES NO
Mental Health Disorders ---------- YES NO
Specify: _____
Recurrent Infections ---------- YES NO
Type of Infection: _____
Kidney Problems ---------- YES NO
Osteoporosis ---------- YES NO
Persistent swollen glands in neck---------- YES NO
Severe headaches/migraines ---------- YES NO
Sexually transmitted disease ---------- YES NO
AIDS or HIV Infection ---------- YES NO

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ---------- YES NO
Name of physician or dentist making recommendation: _____
Do you have any disease, condition, or problem not listed above that you think I should know about? ---------- YES NO
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 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:

_____

FOR COMPLETION BY DENTIST

Comments: