

Health History Form

Email: _____ Cell: (____) _____ Today's date: _____

The following information is vital to allow us to provide appropriate care for you. Your information will be kept confidential subject to applicable laws.

Last name: _____ First name: _____ MI: _____ Home Phone: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Gender: **M F** SSN: _____ - _____ - _____ Height: _____ Weight: _____
 (Required for insurance claims)

Occupation: _____ Emergency contact: _____ Relationship: _____ Phone: (____) _____

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

Your name: _____ Relationship _____

Do you have any of the following conditions? (Check DK if you don't know)

	Y	N	DK
Active Tuberculosis (TB) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough (over 3 weeks) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough that produces blood _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you under a physician's care? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been recently hospitalized? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use tobacco? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use controlled substances (please specify)? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use medicinal or recreational marijuana (please specify)? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you take, or have you taken, oral or IV Biphosphonates like Boniva, Fosamax, Actonel, Reclast, Aredia or any other medication for Osteoprosis or to help increase bone density? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Dental Information

(Check DK if you don't know)

	Y	N	DK
Do your gums bleed while brushing or flossing? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to hot, cold, sweet, or pressure? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you grind/clench your teeth during the day or night (Please specify?) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any jaw pain? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Preferred Pharmacy _____

Y **N** **DK**

Do you experience any clicking or popping of the TMJ? _____

Do you wear a night guard? _____

Do you wear dentures (full or partials)? _____

Date of last dental visit: _____ Date of last dental X-rays: _____

Are you **allergic** to any medications? Please list: _____

Please list all medications you are **taking** (including supplements): _____

Do you have or have you had any of the following?

	Y	N		Y	N		Y	N		Y	N
Cardiovascular Disease			Hemophilia			GI Disease			Convulsions		
Heart Attack			Bld. Transfusion			Gastric Ulcers			Headaches/Migraines		
Stroke			Blood Disorder			Malnutrition			Psychiatric Condition		
Congest. Heart Failure			HIV/AIDS			Eating Disorder			Glaucoma		
Congenital Heart Dis.			Autoimmune Dis.			Thyroid Disease			Osteoporosis		
Heart Murmur			Osteoarthritis			Kidney Disease			Rapid Weight Loss		
Low Blood Pressure			Rheum. Arthritis			Alcoholism			STD		
High Blood Pressure			Lupus			Drug Addiction			Night Sweats		
Mitral Valve Prolapse			Bronchitis			Diabetes- I & II			Excessive Urination		
Pacemaker			Asthma			Cancer			Smoking		
Artificial Heart Valve			COPD			Chemotherapy			Shingles		
Rheumatic Fever			Emphysema			Radiation			Artificial Joints		
Rheum. Heart Disease			Chr. Liver Dis.			Epilepsy			Alzheimer's Disease		
Excessive Bleeding			Cirrhosis			Seizures			Cortisone Therapy		
Anemia			Hepatitis B or C (circle type)			Fainting/Dizziness			Hay Fever		

Any other illness that is not listed above? If "yes," please explain: _____

For women only: Are you:

Pregnant/Trying to get pregnant? **Y N**

Nursing? **Y N**

Taking oral contraceptives? **Y N**

Acknowledgement

I have accurately answered the above questions to the best of my ability. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform D.A. Dental of any changes in the medical status.

Print name: _____ Signature: _____

Parent or Guardian Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

How did you hear about D.A. Dental -----