HEALTH HISTORY FORM

Patient Name _________________________________ Preferred Name ________________________ Date of Birth______________

Name of Primary Care Physician____ Phone Number _(_____)_______________

Emergency Contact _______________________________ Phone _(____)_________________ Relationship ___________________

On a scale of 1-10, with 10 being the highest rating:

How would you rate your overall health?	1	2	3	4	5	6	7	8	9	10
How important is your dental health to you?	1	2	3	4	5	6	7	8	9	10
Where would you rate your current dental health?	1	2	3	4	5	6	7	8	9	10
Where do you want your dental health to be?	1	2	3	4	5	6	7	8	9	10

What would you like to change about your smile?

☐ Color ☐ Bite ☐ Chipped Tooth ☐ Spaces ☐ Crowding ☐ Missing Teeth ☐ Whiter Teeth

Do you have or have ever had:

		Y	N
1	Hospitalization for illness or injury	☐	☐
2	Heart problems, or cardiac stent in last 6 months	☐	☐
3	History of infective endocarditis	☐	☐
4	Artificial heart valve, repaired heart defect (PFO)	☐	☐
5	Pacemaker or implantable defibrillator	☐	☐
6	Congenital heart defect	☐	☐
7	Artificial joint (Date __________________)	☐	☐
8	High blood pressure	☐	☐
9	Low blood pressure	☐	☐
10	Stroke	☐	☐
11	Anemia or other blood disorder	☐	☐
12	Abnormal bleeding	☐	☐
13	Hemophilia	☐	☐
14	Rheumatic or scarlet fever	☐	☐
15	Emphysema/sarcoidosis	☐	☐
16	Tuberculosis	☐	☐
17	Sleep problems or snoring	☐	☐
18	Asthma/breathing problems	☐	☐
19	Kidney disease	☐	☐
20	Thyroid. Parathyroid disease, or calcium deficiency	☐	☐
21	Liver disease	☐	☐
22	Jaundice	☐	☐
23	Hormone deficiency	☐	☐
24	Sinus trouble	☐	☐
25	Stomach or duodenal ulcer	☐	☐
26	Digestive Disorders (gastric reflux)	☐	☐
27	Diabetes (Type I or II) __________________	☐	☐

An ALLERGIC reaction to:

☐ Local anesthetics ☐ Aspirin
☐ Penicillin ☐ Erythromycin
☐ Sulfa Drugs ☐ Codeine/other narcotics
☐ Metals ☐ Latex
☐ Tetracycline ☐ Other: ______________________

		Y	N
28	Osteoporosis/osteopenia (taking bisphosphonates)	☐	☐
29	Arthritis	☐	☐
30	Glaucoma	☐	☐
31	Contact Lenses	☐	☐
32	Head or neck injuries	☐	☐
33	Epilepsy, convulsion, seizures	☐	☐
34	Neurological problems	☐	☐
35	Herpes, viral infections or cold sores	☐	☐
36	Lumps or swelling around the mouth	☐	☐
37	High cholesterol or taking statin drugs	☐	☐
38	STI/STD	☐	☐
39	Hepatitis (type _______________)	☐	☐
40	HIV/AIDS	☐	☐
41	Tumor, abnormal growth	☐	☐
42	Cancer, chemotherapy, radiation therapy	☐	☐
43	Mental health disorder(s)	☐	☐
44	Excessive urination	☐	☐
	ARE YOU:		
45	Presently being treated for any other illness	☐	☐
46	Aware of a change in your health	☐	☐
47	Taking weight management medications (fen-phen)	☐	☐
48	Taking dietary supplements	☐	☐
49	Often exhausted or fatigued	☐	☐
50	FEMALE – are you breastfeeding	☐	☐
51	FEMALE – taking birth control	☐	☐
52	FEMALE – pregnant	☐	☐
53	MALE – prostate disorders	☐	☐
	DO YOU	☐	☐
54	Use alcohol (per week ______________________)	☐	☐
55	Use tobacco (smoke, snuff, or chew) ___________	☐	☐

List all medications, supplements, and/or vitamins taken within the last 2 years

Drug/Dosage	Purpose/Date of last dose	Drug/Dosage	Purpose/Date of last dose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGES IN YOUR MEDICAL HISTORY OR MEDICATIONS

Patients Signature ____ Date ___________________

Doctor's Signature ____ Date ___________________