Health History Form

Before filling out the health history form please read the following two examples of how important it is to give complete and accurate information.

> Patient A is taking birth control pills and does not tell her dentist because she is very young and her parents do not know. She gets an abscessed tooth and needs antibiotics. Antibiotics stop some forms of birth control from working and the patient gets pregnant without knowing why.
>
> Patient B takes a certain form of anti-depressant drug and has heart problems. He does not tell the dentist about the depression medication because he is embarrassed. Some of the epinephrine in the local anesthetic gets into his blood stream, interacts with the anti-depressant, causes his weak heart to race and a heart attack ensues.

Patient's name:____ DOB:____________________________

Do you have any allergies? No:_____ Yes:_____

If yes, please list:

____

____

____

Have you ever been to the hospital for anything other than child birth? No:_____ Yes:_____

If yes, explain when and why:

____

____

____

Do you have any chronic medical conditions? (Diabetes, High Blood Pressure, Hepatitis)

No: _____ Yes: _____

If yes, please list:

____

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____

Are you taking any medication including prescription, over the counter, vitamins or herbal supplements?

No:_____ Yes:_____

If yes, please list name, purpose for taking and dosage (amount and frequency of taking that amount):

____

____

____

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Please answer yes/no to any of the following questions. If yes, please explain in space below:

- Have you had cancer radiological treatment of head/neck? No:_____ Yes:_____
- Have you taken bisphonates (esp Fosamax)? No:_____ Yes:_____
- Are you on birth control? No:_____ Yes:_____
- Are you on any antidepressants? No:_____ Yes:_____
- Have you had steroid or immunosuppressant therapy? No:_____ Yes:_____
- Are you pregnant or trying to get pregnant? No:_____ Yes:_____
- Have you ever had joint replacement surgery? No:_____ Yes:_____
- Do you need to pre-medicate with antibiotics? No:_____ Yes:_____
- Do you wear a pacemaker? No:_____ Yes:_____
    - If yes, is it shielded? No:_____ Yes:_____
    - If you do not know, was it placed after 1985? No:_____ Yes:_____
- Have they ever had an adverse reaction during a dental procedure? No:_____ Yes:_____

____
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____

Physician's name & number:____

Who would you like us to contact in case of emergency? ___________________________
Relationship to you:____

Name of former dentist and date of last visit:_____________________________________

Is there anything you would change about the appearance of your teeth?_______________

Which of the following better describes you? 1-If it doesn't hurt a little, I don't feel like I was totally cleaned. 2-I like to get 100% clean as gentle as possible. Check 1 - ☐ or 2 - ☐.

I have reviewed the information on this page and it is accurate to the best of my knowledge. If there are any changes to my medical status, I will inform the office. I understand that the following are potential complications that can occur with any dental treatment, and although not common, they can occur to me: bruising or paresthesia (prolonged or permanent numbness) with anesthetic injections, TMJ (jaw bones and muscles) pain or problems from opening of the mouth for extended periods of time, soreness or swelling in and around the mouth from stretching and use of instruments, damage to adjacent teeth or prolonged sensitivity when work is done on any tooth, if cavities are larger than expected the price may increase and sometimes a root canal may be needed if cavity is larger than expected.

Initials for digital signature:__________ Name:_____________________ Date:_________________