NORTHWEST COLORADO HEALTH

DENTAL HEALTH HISTORY FORM

Patient Name: _____ **Date of Birth:**_____

Existing Patients: Please check this box and initial if your health history has NOT changed in the last 12 months ☐ _____

Are you currently under a physician's care? ☐Yes ☐No If yes: _____

Preferred Pharmacy: _____ **City, State**: _____

Medication / Supplement	**Dosage/Strength, Frequency**
Allergies	**Reaction**

Are you current on your immunizations: ☐ YES ☐ NO ☐ UNSURE

General Health History – Check if you have had any of the following							
AIDS/HIV Positive		Cold Sores/Fever Blisters		Hemophilia		Serious Head Injury	
Alzheimer's Disease		COPD		Hepatitis A		Serious Neck Injury	
Angina		Cortisone Medication		Hepatitis B or C		Sickle Cell Disease	
Artificial Heart Valve		Diabetes I or II		High Blood Pressure		Sinus Trouble	
Artificial Joint		Emphysema		Low Blood Pressure		Stroke	
Asthma		Fainting/Dizziness		Mitral Valve Prolapse		Substance Abuse	
Cancer		Heart Pacemaker		Pain in Jaw Joints		Thyroid Disease	
Chemotherapy		Heart Trouble/Disease		Rheumatic Fever			
Other:							

Has a physician or previous dentist recommended that you take antibiotics prior to your dental appointments?	☐ YES ☐ NO If Yes, please explain:
Women: Are you….	☐Pregnant/Trying to get pregnant? ☐Nursing? ☐Taking oral contraceptives?

Surgical History	
Date	**Type of Surgery / Procedure**

Medical / Psychiatric Hospitalization History	
Date	**Reason for Hospitalization**

Revised: 05.10.2017

Family History

Family Member	Status	How Old?	Medical / Mental Health Illness / Disease
Father	Alive / Deceased		
Mother	Alive / Deceased		
Paternal Grandfather	Alive / Deceased		
Paternal Grandmother	Alive / Deceased		
Maternal Grandfather	Alive / Deceased		
Maternal Grandmother	Alive / Deceased		
Sister(s)	Alive / Deceased		
Brother(s)	Alive / Deceased		
Children	Alive / Deceased		
Other Relatives	Alive / Deceased		

Social History

Do you currently use tobacco?	☐ YES ☐ NO
Do you have access to food on an ongoing basis?	☐ YES ☐ NO
Do you have access to safe and secure housing?	☐ YES ☐ NO
Do you have access to transportation to get to your medical appointments?	☐ YES ☐ NO
If you have guns in your house, are they locked and unloaded?	☐ YES ☐ NO
Have you ever been forced to have sex?	☐ YES ☐ NO
Have you ever been hit, slapped, kicked, shaken or hurt by anyone?	☐ YES ☐ NO
Is there anyone that makes you feel unsafe now?	☐ YES ☐ NO
Do you / Did you ever experience Domestic Violence?	☐ YES ☐ NO
Do you / Did you ever experience Sexual Abuse?	☐ YES ☐ NO

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____