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** |
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|  |  |
| **Allergies** | **Reaction** |
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**Are you current on your immunizations:** [ ]  YES [ ]  NO [ ]  UNSURE

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| --- |
| **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** |
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| **Medical / Psychiatric Hospitalization History** |
| **Date** | **Reason for Hospitalization** |
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|  |  |
|  |  |
|  **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_