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**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **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 | |  |  |  |
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| Other: |  | | | | | | | | | | | | | |
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| Has a physician or previous dentist recommended that you take antibiotics prior to your dental appointments? | | | | | | | YES  NO If Yes, please explain: | | | | | | | |
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| 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_