ADA® American Dental Association
www.ada.org

Medical Alert:	Condition:	Premedication:	Allergies:	Anesthesia:	Date:

HEALTH HISTORY FORM

Name: Title: Date of Birth: Sex M ❑ F ❑

Address: City State: Zip Code:

Business Phone: ( ) Home Phone: ( ) Cell Phone: ( )

SS#: Emergency Contact: Relationship: Phone: ( )

Email: Occupation:

If you are completing this form for another person, what is your name and relationship to that person?

Name: Relationship:

For the following questions, please check whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

DENTAL INFORMATION FOR NEW PATIENTS ONLY

	Yes	No	Don't Know
	(please check answer)		
Do your gums bleed when you brush	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Do you have earaches or neck pains?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Do you wear removable dental appliances?	☐	☐	☐
Have you had a serious difficult problem associated with any previous dental treatment?	☐	☐	☐

If yes, explain: _____

How would you describe your current dental problem. _____

Date of your last dental exam: _____

Date of last dental x-rays? _____

What was done at that time? _____

How do you feel about the appearance of your teeth? _____

MEDICAL INFORMATION

If you answer yes to any of the 4 items below, please stop and return this form to the receptionist.	Yes	No	Don't Know
	(please check answer)		
Have you had any of the following diseases or problems?			
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Have you had a stroke, heart attack or surgery in the last 6 months?	☐	☐	☐

Primary Physician: _____
NAME CITY/HOSPITAL

Specialist: _____
NAME CITY/HOSPITAL SPECIALTY

Specialist: _____
NAME CITY/HOSPITAL SPECIALTY

Specialist: _____
NAME CITY/HOSPITAL SPECIALTY

Have you had any health problems, operations, or been hospitalized in the past 5 years? ☐ ☐ ☐

If yes, plese explain: _____

	Yes	No	Don't Know
	(please check answer)		
Have you ever taken bisphosphonate or other bone strengthening medications?	☐	☐	☐
IV FORM?_____ Other? _____			
Are you taking blood thinners?	☐	☐	☐
Are you alcohol and/or drug dependent? Yes / No (circle one)			
If yes, when did you receive treatment?_____			
Do you use tobacco (smoking, snuff, chew)?	☐	☐	☐
If yes, how interested are you in stopping? (circle one) Very / Somewhat / Not interested			
Do you wear contact lenses?	☐	☐	☐

WOMEN ONLY

Are you or could you be pregnant?	☐	☐	☐
Nursing?	☐	☐	☐
Are you taking birth control pills?	☐	☐	☐
Are you taking hormone replacements?	☐	☐	☐

PLEASE COMPLETE BOTH SIDES

Are you allergic to or have you had a reaction to?	Yes	No	Don't Know
(please check a response & add date where applicable)			
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin	☐	☐	☐
Other antibiotics (please list) _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Latex	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food (specify) _____	☐	☐	☐
Other (specify) _____	☐	☐	☐
Metals (specify) _____	☐	☐	☐

To yes responses, specify type of reaction.

_____

_____

_____

	Yes	No	Don't Know
(please check a response & add a date where appplicable)			
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
If yes, when was this operation done? _____			
If you answered yes to the above question, have you had any complications or difficulties with your prosthetic joint? _____			
Do you have a congenital heart defect or had surgery to repair a heart valve?	☐	☐	☐
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

If yes, what antibiotic and dose? _____

Name of physician or dentist: _____

Phone: _____

Please check a response & add a date where applicable to indicate if you have had any of the following diseases or problems.

	Yes	No	Don't Know
(please check a response & add date where applicable)			
Abnormal bleeding	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Anemia	☐	☐	☐
Arthritis	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Asthma	☐	☐	☐
Type of Inhaler: _____			
Blood transfusion	☐	☐	☐
Cancer/Chemotherapy/Radiation Treatment	☐	☐	☐
Type: _____			
Dates of treatment: _____			
Cardiovascular disease. If yes, specify below:	☐	☐	☐

_____Angina
_____Arteriosclerosis
_____Artificial heart valve
_____Congenital heart defects
_____Congestive heart failure
_____Coronary artery disease
_____Damaged heart valves
_____**Heart attack Date:**_____
_____Heart murmur
_____High blood pressure
_____Low blood pressure
_____Mitral valve prolapse
_____Pacemaker
_____Rheumatic heart disease/Rheumatic fever
_____Blood Clots

Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Disease, drug, or radiation-induced immunosuppression	☐	☐	☐
Diabete ___Type I (insulin dependent) ___Type IIs	☐	☐	☐
What is your most recent A1C level? _____			
Dry Mouth	☐	☐	☐
Eating disorder. If yes, specify: _____	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Glaucoma	☐	☐	☐
Hemophilia	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Recurrent Infections	☐	☐	☐
If yes, indicate type of infection:_____	☐	☐	☐

	Yes	No	Don't Know
Kidney problems	☐	☐	☐
Days of Dialysis: _____			
Mental health disorders. If yes, specify:_____	☐	☐	☐
Malnutrition	☐	☐	☐
Night sweats	☐	☐	☐
Neurological disorders. If yes, specify: _____	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Respiratory problems. If yes, specify below:	☐	☐	☐
___Emphysema ___Bronchitis, etc.			
Severe headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sinus trouble	☐	☐	☐
Sleep disorder	☐	☐	☐
Sores or ulcers in the mouth	☐	☐	☐
Stroke Date:_____	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Tuberculosis	☐	☐	☐
Thyroid problems	☐	☐	☐
Ulcers	☐	☐	☐
Excessive urination	☐	☐	☐
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

Please explain:

_____

MEDICATIONS

	Yes	No	Don't Know
Are you taking or have you recently taken any medicine(s) including non-prescription medicine?	☐	☐	☐

If yes, what medicine(s) are you taking? _____

_____

_____

_____

_____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____

Signature of patient or legal guardian **Date**