

Name _____ Home Phone () _____ Business Phone () _____
Last First Middle

Address _____ City _____ State _____ Zip Code _____
P.O. Box or Mailing address

Occupation _____ Height _____ Weight _____ Date of Birth ____/____/____ Sex M F

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

If you are completing this form for another person, what is your relationship to that person? _____
Name Relationship

For the following questions, please (X) 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

Yes	No	Don't Know		Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do your gums bleed when you brush?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had orthodontic (braces) treatment?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have headaches, earaches or neck pains?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear removable dental appliances?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a serious/difficult problem associated with any previous dental treatment? If so, 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

Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you in good health?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has there been any change in your general health within the past year?

Do you have any of the following diseases or problems: **If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.**

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Active Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough greater than a 3 week duration
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cough that produces blood

Are you now under the care of a physician? If so, what is/are the condition(s) being treated? _____
 Date of last physical examination _____

Physician(s)

NAME	PHONE	ADDRESS	CITY/STATE/ZIP
_____	_____	_____	_____
_____	_____	_____	_____

Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, what was the illness or problem? _____

Are you taking or have you recently taken any medicine(s) including non-prescription medicine? If so, what medicine(s) are you taking?
 Prescribed _____
 Over the counter _____
 Natural or herbal preparations _____

Have you taken any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?

Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the last 24 hours? _____ In the past month? _____
 If yes, _____ # of drinks per day for _____ # of years

Are you alcohol and/or drug dependent? If so, have you received treatment? (Check one) Yes No

Do you use drugs or other substances for recreational purposes? If yes, please list _____
 Frequency of use (daily, weekly, etc.) _____ Number of years of recreational drug use _____

Do you use tobacco (smoking, snuff, chew)? If so, how interested are you in stopping? (Check one) Very Somewhat Not interested

Do you wear contact lenses?

Allergies Are you allergic to or have you had a reaction to: (Please fill out both columns)

Yes	No	Don't Know		Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Local anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/seasonal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates, sedatives, or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Animals
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food (Specify) _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (Specify) _____

To yes responses, specify type of reaction _____

Yes No Don't Know

(Women Only)

- Are you pregnant?
Nursing?
Taking birth control pills?

- Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?
Have you had any complications or difficulties with your prosthetic joint?
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

NOTE TO PATIENT: A new report (July 1997) prepared and endorsed by the American Dental Association and the American Academy of Orthopaedic Surgeons has recommended that antibiotic prophylaxis before dental treatment is not indicated for most dental patients with artificial orthopedic prosthetic joints.

Please (X) if you have or had any of the following diseases or problems.

Table with 3 columns: Yes, No, Don't Know. Rows include various medical conditions such as Abnormal bleeding, AIDS, Anemia, Arthritis, Rheumatoid arthritis, Asthma, Blood transfusion, Cancer/chemotherapy/radiation treatment, Cardiovascular disease, Diabetes, Epilepsy, Fainting spells or seizures, G.E. reflux, Glaucoma, Hemophilia, Hepatitis, jaundice or liver disease, Kidney problems, Low blood pressure, Mental health disorders, Malnutrition, Migraines, Night sweats, Neurological disorders, Osteoporosis, Persistent swollen glands in neck, Respiratory problems, Severe headaches, Severe or rapid weight loss, Sexually transmitted disease, Sinus trouble, Sleep disorder, Sores or ulcers in the mouth, Stroke, Systemic lupus erythematosus, Thyroid problems, Tuberculosis, Ulcers, Excessive urination.

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.

Signature of Patient/Legal Guardian Date

For completion by dentist

Comments on patient interview concerning health history

Significant findings from questionnaire or oral interview

Dental management considerations

Signature of Dentist Date

Health History Update: On a regular basis the patient should be questioned about any medical history changes, date and comments notated, along with signature.

Date Comments Signature of patient and dentist