PATIENT INFORMATION

Date

NAME: First, MI, Last	Patient Employer
ADDRESS	Address
City State Zip	City State Zip
Home Phone Work Phone	Occupation
Cellular E-mail	Emergency Contact
Date of Birth Age Sex ☐M ☐F Marital Status	Phone Relationship to Patient
Referring Dentist	Medical Physician
Referring Orthodontist	Phone #
Wife/Mother Name:	Husband/Father Name:
Address	Address
City State Zip	City State Zip
Home Phone Work Phone	Home Phone Work Phone
Cellular Date of Birth	Cellular Date of Birth
Employer	Employer

What are we seeing you for today?

1. Are you in good health? ..... YES NO
2. Has there been any change in your general health in the last year? ..... YES NO
3. Are you now under a physicians care for a particular problem? ..... YES NO
4. Have you had any serious illnesses, operations or hospitalizations? ..... YES NO
   If so, describe
5. Have you ever had excessive bleeding requiring special treatment? ..... YES NO
6. Are you subject to fainting, dizziness, convulsions, seizures or epilepsy? ..... YES NO
7. Have you ever had Asthma, Emphysema, Tuberculosis, Pneumonia or difficulty breathing? ..... YES NO
8. Have you ever had any of the following:
   a) Heart Problem ..... YES NO
   b) Stroke ..... YES NO
   c) Rheumatic Fever or Heart Murmur ..... YES NO
   d) Liver Disease, Hepatitis, Jaundice ..... YES NO
   e) Kidney Disease ..... YES NO
   f) High or Low Blood Pressure ..... YES NO
   g) Diabetes ..... YES NO
   h) Anemia ..... YES NO
   i) Stomach Ulcers ..... YES NO
   j) Thyroid Disease (goiter) ..... YES NO
   k) Glaucoma ..... YES NO
   l) Implants placed anywhere in your body (heart valve, hip, knee) ..... YES NO
   m) Any disease, drugs or transplant operation that has depressed your immune system ..... YES NO
   n) AIDS / ARC / HIV ..... YES NO
9. Are you wearing contact lenses? ..... YES NO
10. Are you using or taking any of the following:
    a) Antibiotics ..... YES NO
    b) Anticoagulants (Plavix, Coumadin) ..... YES NO
    c) High Blood Pressure medication ..... YES NO
    d) Steroids (Cortisone) ..... YES NO
    e) Tranquilizers (Valium) ..... YES NO
    f) Insulin or oral Diabetes medicine ..... YES NO
    g) Digitalis, Inderal, Nitroglycerine or other heart medicine ..... YES NO
    h) Aspirin ..... YES NO
    i) Osteoporosis medications (Fosamax, Actonel, Boniva) ..... YES NO
    j) WOMEN: Birth Control pills ..... YES NO

    PLEASE LIST ALL CURRENT MEDICATIONS:
11. Please list all medication allergies:
12. Do you smoke or use smokeless tobacco products? ..... YES NO
13. Have you ever sought treatment for drug abuse or alcoholism? ..... YES NO
14. Do you have other medical conditions or concerns that the doctor should know about? ..... YES NO
15. Have you ever been treated for or diagnosed with TMJ (JawJoint) pain, noise or limited function? ..... YES NO
16. Do you currently have TMJ problems? ..... YES NO
17. WOMEN: Are you pregnant or planning pregnancy? ..... YES NO
18. Are you allergic to eggs or sulfites? ..... YES NO

I understand the information I provide on this form is essential to determine my dental needs and the provision of treatment. I understand that if any change occurs in my health I will report it to the office as soon as possible. I have read and understand these questions and answered them all truthfully and to the best of my ability, and I have had an opportunity to discuss my health history with the doctor.

Signature of persons completing health history

Doctor's Initials

Print Form