Health History Form

PARKLAND PACIFIC DENTAL

Your privacy is important to us, and the information you provide is for our records only and will be kept confidential. This information is vital to allow us to provide appropriate care for you.

Name: *Last*	*First*	*Middle*	**Today's Date:**
Email:		**Home Phone:** ( )	**Business/Cell Phone:** ( )
Address:	**City:**	**State:**	**Zip:**
Occupation:	**Height:**	**Weight:**	**Date of Birth:**
Sex: M F	**SS #:**	**Emergency Contact:**	**Phone Number:** ( )
If you are completing this form for another person, what is your relationship?			
Your Name		*Relationship*	

DO YOU HAVE ANY OF THE FOLLOWING DISEASES OR PROBLEMS?	**YES**	**NO**	**DK**
Active Tuberculosis……	☐	☐	☐
Persistent cough greater than a 3-week duration……	☐	☐	☐
Cough that produces blood……	☐	☐	☐
Been exposed to anyone with Tuberculosis……	☐	☐	☐

If you have any of the 4 items above, please stop and return this form to the receptionist.

DENTAL INFORMATION *For the following questions, please mark (X) for your responses.*

	YES	**NO**	**DK**		**YES**	**NO**	**DK**
Do your gums bleed when you brush or floss?……	☐	☐	☐	Do you have earaches or neck pains?……	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets, or pressure……	☐	☐	☐	Do you have any clicking, popping, or discomfort in the jaw?……	☐	☐	☐
Is your mouth dry?……	☐	☐	☐	Do you clench or grind your teeth?……	☐	☐	☐
Have you had any problems associated with previous dental treatment?……	☐	☐	☐	Have you ever had a serious injury to your head or mouth?……	☐	☐	☐
Have you had any periodontal (gum) treatments?……	☐	☐	☐	Do you have sores or ulcers in your mouth?……	☐	☐	☐
Are you currently experiencing dental pain?……	☐	☐	☐	Do you wear dentures or partials?……	☐	☐	☐

Reason for your dental visit today:
_____

Date of:
Last dental exam: _____ *Last dental x-rays:* _____

Why did you leave your previous dentist?
_____

How do you feel about your smile?
_____

MEDICAL INFORMATION *For the following questions, please mark (X) to indicate if you have or have not had any of the following diseases or problems listed.*

	YES	**NO**	**DK**		**YES**	**NO**	**DK**
Are you under the care of a physician?……	☐	☐	☐	Are you in good health?……	☐	☐	☐
Physician Name: _____	**Phone:** ( )			Has there been any change in your general health within the past year?……	☐	☐	☐
Address/City/State/Zip: _____				**If yes, what was the illness or problem?** _____			

Date of last physical exam:	**Please list all, prescription or over the counter medications including vitamins, natural or herbal preparations and/or dietary supplements:**

MEDICAL INFORMATION *For the following questions, please mark (X) to indicate if you have or have not had any of the following diseases or problems listed.*

	YES	NO	DK		YES	NO	DK
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?……	☐	☐	☐	Do you use controlled substances (drugs)?……	☐	☐	☐
If yes, provide date and any complications associated with joint replacement: _____				Do you use tobacco (smoking, snuff, chew, bidis)?……. **If so, how interested are you in stopping?** *Circle one:* VERY / SOMEWHAT / NOT INTERESTED	☐	☐	☐
Have you had a serious illness, operation or been hospitalized in the past 5 years?……	☐	☐	☐	Do you drink alcoholic beverages?……..…	☐	☐	☐
If yes, provide date and what the illness or problem was: _____				**If yes, how much did you drink in the last 24 hours?** _____			
Are you taking or will take an antiresorptive agent (Fosamax, Actonel, Bonvica, Reclast, Prolia) for osteoporosis or Paget's disease?……..	☐	☐	☐	**WOMEN ONLY:** Are you: Pregnant…….. **If so, how many weeks?** _____	☐	☐	☐
				Taking birth control or hormone replacement?……..	☐	☐	☐
Since 2001, were you treated or will be treated with an antiresportive agent (listed above), for bone pain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer? **Date treatment began:**_____	☐	☐	☐	Nursing?……	☐	☐	☐

ALLERGIES: Are you allergic or have had a reaction to medication or any other thing? Mark (X) for all that apply. If **yes**, specify the type of reaction.

Antibiotics……	☐	☐	☐	Local anesthetics……..	☐	☐	☐
Codeine or other narcotics……	☐	☐	☐	Latex (rubber)……..…	☐	☐	☐
Metals……..……..	☐	☐	☐	Other: _____	☐	☐	☐

Do you have or have had any of the following?

	YES	NO	DK		YES	NO	DK		YES	NO	DK		YES	NO	DK
Artificial (prosthetic) heart valve……	☐	☐	☐	**Cardiovascular disease……**	☐	☐	☐	**Mitral valve relapse……..**	☐	☐	☐	**Sleep disorder..**	☐	☐	☐
Previous infective endocarditis…..	☐	☐	☐	**Angina……**	☐	☐	☐	**Abnormal bleeding……..**	☐	☐	☐	**Emphysema……**	☐	☐	☐
Persistent swollen glands in neck……..	☐	☐	☐	**High Cholesterol……**	☐	☐	☐	**Anemia……**	☐	☐	☐	**Sinus trouble….**	☐	☐	☐
Congenital heart disease……	☐	☐	☐	**Congestive heart failure……..**	☐	☐	☐	**Hemophilia…….**	☐	☐	☐	**Tuberculosis…..**	☐	☐	☐
Severe weight loss……..	☐	☐	☐	**Damaged heart valves……..**	☐	☐	☐	**AIDS or HIV infection……..**	☐	☐	☐	**Cancer/ Chemotherapy/ Radiation……**	☐	☐	☐
Heart attack……	☐	☐	☐	**Severe headaches or migraines……**	☐	☐	☐	**Arthritis……**	☐	☐	☐	**Chest pain upon exertion……**	☐	☐	☐
If yes, provide date: _____				**Heart murmur……**	☐	☐	☐	**Autoimmune disease……**	☐	☐	☐	**Chronic pain….**	☐	☐	☐
Pacemaker……..	☐	☐	☐	**Low blood pressure……..**	☐	☐	☐	**Rheumatoid arthritis……**	☐	☐	☐	**Diabetes Type I or II……**	☐	☐	☐
Rheumatic fever……	☐	☐	☐	**High blood pressure……..**	☐	☐	☐	**Asthma……**	☐	☐	☐	**Eating disorder..**	☐	☐	☐
G.E. Reflux/ persistent heartburn……	☐	☐	☐	**Glaucoma……**	☐	☐	☐								

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	YES	NO	DK		YES	NO	DK		YES	NO	DK		YES	NO	DK
Rheumatic heart disease…	☐	☐	☐	**Other heart defects……**	☐	☐	☐	**Bronchitis…….**	☐	☐	☐	**Gastrointestinal disease……**	☐	☐	☐
Ulcers……	☐	☐	☐	**Hepatitis, jaundice or liver disease….**	☐	☐	☐	**Stroke……**	☐	☐	☐	**Osteoporosis…**	☐	☐	☐
Thyroid problems……	☐	☐	☐	**Epilepsy……**	☐	☐	☐	**Fainting spells……**	☐	☐	☐	**Kidney problems……**	☐	☐	☐
Blood transfusion……	☐	☐	☐	**Mental health disorders……**	☐	☐	☐	**Neurological disorders……**	☐	☐	☐	**Recurrent infection…….**	☐	☐	☐
If yes, provide date: _____				**If yes, specify:** _____				**If yes, specify:** _____				**If yes, type of infection:** _____			

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐
If yes, provide name and number of physician or dentist making recommendation: _____			
Do you have any disease, condition, or problem not listed that you think I should know about? If yes, please explain. _____			

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 and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. 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 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.

PATIENT SIGNATURE: _____ **DATE:** _____	**DENTIST SIGNATURE:** _____ **DATE:** _____

FOR COMPLETION BY DENTIST ONLY
COMMENTS: