Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Referring doctor:	**Date of last physical exam:**
Height:	**Weight:**

PERSONAL HEALTH HISTORY

Reason for visit:		
List any medical problems that other doctors have diagnosed:		
Surgeries		
Year	Reason	Hospital
Other hospitalizations		
Year	Reason	Hospital

List your prescribed drug(s) and over-the-counter medication(s)		
Drug Name	Strength	Frequency Taken

Allergies to medications	
Drug Name	Reaction (Itching, hives, nausea, shortness of breath)

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?	#of drinks/week			
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you use any recreational drugs?			☐ Yes	☐ No
	If yes, what kind:				
Health	Are you in good health?			☐ Yes	☐ No
	Has there been any change in your general health in the past year?			☐ Yes	☐ No
	Are you now under a physician's care for a particular problem? If yes, please describe:			☐ Yes	☐ No
	Have you had any serious problems associated with any previous dental treatment?			☐ Yes	☐ No
	Have you or an immediate family member had any problem associated with intravenous anesthesia?			☐ Yes	☐ No
	Do you wish to talk to the doctor privately about anything not listed here?			☐ Yes	☐ No
	Have you ever had a bone density scan?			☐ Yes	☐ No
	Do you take antibiotics before your dental appointment?			☐ Yes	☐ No
	Do you have any other disease, condition or problem not listed above that you think the doctor should know about?			☐ Yes	☐ No
	Do you have or have you ever had:				
	Rheumatic fever or rheumatic heart disease?			☐ Yes	☐ No
	Congenital heart disease?			☐ Yes	☐ No
	Cardiovascular disease (heart attack, heart murmur, high blood pressure, etc.)?			☐ Yes	☐ No
	Lung disease (asthma, COPD, chest pain, etc.)?			☐ Yes	☐ No

	Seizures, convulsions, epilepsy, fainting, or dizziness?	☐ Yes	☐ No
	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	☐ Yes	☐ No
	Liver disease (jaundice, hepatitis)?	☐ Yes	☐ No
	Kidney disease?	☐ Yes	☐ No
	Diabetes?	☐ Yes	☐ No
	Thyroid disease (goiter)?	☐ Yes	☐ No
	Arthritis?	☐ Yes	☐ No
	Stomach ulcers or colitis?	☐ Yes	☐ No
	Glaucoma?	☐ Yes	☐ No
	Osteoporosis?	☐ Yes	☐ No
	Implants placed anywhere in your body (heart valve, pacemaker, hip, knee, etc.)?	☐ Yes	☐ No
	Radiation (X-Ray) treatment for cancer?	☐ Yes	☐ No
	Clicking or popping of jaw joint, pain near ear, grind or clench teeth?	☐ Yes	☐ No
	Sinus or nasal problems?	☐ Yes	☐ No
	Chronic or acute pain disorder (fibromyalgia, neck pain, back pain, etc.)?	☐ Yes	☐ No
	Any disease, drug or transplant operation that has depressed your immune system?	☐ Yes	☐ No
	Are you using any of the following:		
	Antibiotics?	☐ Yes	☐ No
	Anticoagulants (blood thinners)?	☐ Yes	☐ No
	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	☐ Yes	☐ No
	High blood pressure medications?	☐ Yes	☐ No
	Steroids (Cortisone, Prednisone, etc.)?	☐ Yes	☐ No
	Tranquilizers?	☐ Yes	☐ No
	Insulin or Oral Anti-Diabetic drugs?	☐ Yes	☐ No
	Digitalis, Inderal, Nitroglycerin or other heart drugs?	☐ Yes	☐ No
	Are you taking or have you ever taken Bisphosphonates for Osteoporosis, Multiple Myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia)?	☐ Yes	☐ No
	Are you allergic to or have had an adverse reaction to:		
	Local anesthesia?	☐ Yes	☐ No
	Penicillin or other antibiotics?	☐ Yes	☐ No
	Sedatives, barbiturates?	☐ Yes	☐ No
	Aspirin or Ibuprofen?	☐ Yes	☐ No
	Codeine or other pain killers?	☐ Yes	☐ No
	Latex or rubber products?	☐ Yes	☐ No
	Metal of any kind?	☐ Yes	☐ No
	Chemicals or jewelry (rash or sensitivity)?	☐ Yes	☐ No
	Food products?	☐ Yes	☐ No
	If not listed above, please indicate any other allergic reactions you may have had:		

MENTAL HEALTH

Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide for you?	☐ Yes	☐ No

WOMEN ONLY

Are you pregnant or is there any chance you might be pregnant?	☐ Yes	☐ No
Are you nursing?	☐ Yes	☐ No

If you are using oral contraceptives it is important that you understand that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

OTHER PROBLEMS

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible. I have had the opportunity to discuss my health history with my doctor.

X _____

Signature of Person Completing Health History

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

X _____

Signature of Patient or Guardian/Guarantor

X _____

Signature of Doctor