New Patient Health History Information

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that 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.

Date ________ /________ / ________

Name: First ______________________________________ Last ___________________________________ Preferred _______________________

DOB __________________ Occupation ____ Height ________________ Weight _____________

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

Do you have any of the following diseases or problems:

Active tuberculosis .... ☐ Yes ☐ No ☐ N/A
Persistent cough greater than a 3 week duration .... ☐ Yes ☐ No ☐ N/A
Cough that produces blood .... ☐ Yes ☐ No ☐ N/A
Been exposed to anyone with tuberculosis .... ☐ Yes ☐ No ☐ N/A

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

Dental Information

	Yes	No	N/A
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Are you currently experiencing dental pain or discomfort?	☐	☐	☐
Do you have earaches or neck pain?	☐	☐	☐

	Yes	No	N/A
Do you have any clicking or popping or discomfort in the jaw?	☐	☐	☐
Do you clench or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental appointment: _________________________________

What was done at that time? ____

Date of last dental x-rays: ____

How do you feel about your smile? ____

Do you have any dental concerns at this time? ☐ Yes ☐ No ☐ N/A ____

Medical Information

Are you under the care of a physician now? .... ☐ Yes ☐ No ☐ N/A

If yes, *Physician Name:* ____ *Phone #* _______________________________

Are you in good health? .... ☐ Yes ☐ No ☐ N/A

Have there been any changes to your general health within the last year? .... ☐ Yes ☐ No ☐ N/A ____

Have you had a serious illness, operation or been hospitalized in the last 5 yrs?.. ☐ Yes ☐ No ☐ N/A ____

Are you taking any prescription or over the counter medicines? .... ☐ Yes ☐ No ☐ N/A

Please List: ____

Do you use controlled substances (drugs)? .... ☐ Yes ☐ No ☐ N/A

Do you use tobacco (smoking, snuff, chew, bidis)? .... ☐ Yes ☐ No ☐ N/A
If yes, how interested are you in stopping? (circle one) VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? .... ☐ Yes ☐ No ☐ N/A
If yes, how much in the last 24 hours? __________________________ *If yes, how much do you typically drink in a week*? ____________________________

Medical Information Continued

Joint Replacement - Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)? .... ☐ Yes ☐ No ☐ N/A

Date ________________________ Which joint? ______________________

Women only - Are you?

Pregnant? .... ☐ Yes ☐ No ☐ N/A

If yes, number of weeks __________________

Nursing? .... ☐ Yes ☐ No ☐ N/A

Taking oral contraceptives? .... ☐ Yes ☐ No ☐ N/A

Bisphosphonates - Have you ever taken **Fosamax**, **Boniva**, **Actonel** or any other medications containing ***Bisphosphonates*** for Osteoporosis or Paget's Disease? .... ☐ Yes ☐ No ☐ N/A

Since 2001, have you been treated with ***Intravenous Bisphosphonates*** like **Aredia** or **Zometa** for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?.. ☐ Yes ☐ No ☐ N/A

Date treatment began ______________________

Are you ***allergic*** to or have you had a reaction to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metals ☐ Latex ☐ Sulfa Drugs ☐ Iodine ☐ Local Anesthetics
☐ Barbiturates, sedatives, or sleeping pills ☐ Antibiotics ☐ Medications ☐ Food ☐ Animals ☐ Seasonal ☐ Other

If *other* allergy please explain: ____

**Except for the conditions listed in this box, antibiotic prophylaxis is no longer recommended for any other form of CHD.*

Congenital heart disease (CHD)

Unrepaired, cyanotic CHD .... ☐ Yes ☐ No ☐ N/A
Repaired (completely) in last 6 months .... ☐ Yes ☐ No ☐ N/A
Repaired CHD with residual defects .... ☐ Yes ☐ No ☐ N/A
Artificial (prosthetic) heart valve .... ☐ Yes ☐ No ☐ N/A
Previous infective endocarditis .... ☐ Yes ☐ No ☐ N/A
Damaged valves in transplanted heart .... ☐ Yes ☐ No ☐ N/A

Circle if you have, or have had, any of the following diseases or problems:

AIDS/HIV Positive	Chemotherapy	GE Reflux/ heartburn	Leukemia	Sexually Transmitted Disease
Alzheimer's disease	Chest Pains	Genital Herpes	Liver Disease/ Jaundice	Shingles
Anaphylaxis	Cold Sores/ Fever Blister	Glaucoma	Low Blood Pressure	Sickle Cell Disease
Anemia	Congestive Heart Failure	Heart Attack/ Failure	Lung Disease	Sinus Trouble
Angina	Convulsions	Heart Murmur*	Lupus	Sjogren's Syndrome
Arteriosclerosis	Cortisone Medicine	Heart Pace Maker*	Mental Health Disorder	Sleep Disorder
Arthritis/ Gout	Damaged Heart Valves	Heart Trouble/ Disease	Mitral Valve Prolapse*	Spina Bifida
Asthma	Depression	Hemophilia	Neurological Disorder	Stomach/ Intestinal Disease
Autoimmune Disease	Diabetes - Type I or II	Hepatitis A	Pacemaker	Stroke
Blood Disease	Drug Addiction	Hepatitis B or C	Parathyroid Disease	Swell of limbs
Blood Transfusion	Eating Disorder	Herpes	Osteoporosis	Swollen glands in neck
Breathing Problem	Emphysema	High Blood Pressure	Radiation Treatments	Thyroid Disease
Bronchitis	Epilepsy or Seizures	Hives or Rash	Renal Dialysis	Tonsillitis
Bruise Easily	Excessive Bleeding	Hypoglycemia	Rheumatic Fever*	Tuberculosis
Cancer	Excessive Thirst/ Urination	Irregular Heartbeat	Rheumatism	Ulcers
Cardiovascular Disease	Fainting Spells/ Dizziness	Kidney Problems	Scarlet Fever	Venereal Disease

Has a Physician or previous Dentist recommended that you take antibiotics prior to dental treatment?.. ☐ Yes ☐ No ☐ N/A

Name of Physician or Dentist making this recommendation ______________________________ *Phone Number* ____________________

Do you have any disease, condition, or problem not listed above that you think I should know about? .... ☐ Yes ☐ No ☐ N/A

If yes, please explain ____

Additional Comments ____

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, 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 Guardian ____ Date ____________________

Dentist and staff comments ONLY

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