

Patient Health History Form

Although dental personnel primarily treat the area in and around your mouth, it's important to remember that your mouth is part of your whole body. Existing health conditions or medications you are taking could have an important interrelationship with the dentistry you will receive. Thank you for taking the time to answer the following questions.

Full Name: _____ Date of Birth: _____

Preferred Name: _____

Emergency contact name, relationship, and phone number: _____

What are your preferred pronouns?

- He/Him/His
 She/Her/Hers

- They/Them/Theirs
 Other: _____

MEDICAL HISTORY:

1. Are you under a physician's care now?

- Yes - Name of Physician: _____
 No

2. Are you taking any medications or supplements, either prescribed or over the counter?

- Yes
 No

If yes, please list them, and what they are taken for: _____

3. Have you ever been hospitalized or had a major operation?

- Yes
 No

If yes, why/when? _____

4. Have you ever had a serious head or neck injury?

Yes

No

If yes, what happened/when? _____

5. Do you have any physical or psychological challenges that need to be accommodated for?

Yes

No

If yes, how can we accommodate? _____

6. Are you taking a blood thinner or anti-clotting medication?

Yes

No

If yes, what and when was your most recent INR? _____

7. Have you ever taken or are scheduled to take a bisphosphonate medication, oral or IV, such as Fosomax, Boniva, Actonel, Zometa, Aredia, Didronel, etc, or other bone-strengthening medications for osteoporosis, Paget's disease, or other bone disease?

Yes - If yes, which one? _____

No

8. Do you use nicotine?

Yes - What form and how often? _____

No

9. Have you used nicotine in the past?

Yes - What form and when did you quit? _____

No

10. Do you use Marijuana/THC?

Yes - What form and how often? _____

No

11. Do you use any other controlled substances?

Yes - What and how often? _____

No

12. Do you use alcohol on a daily basis?

Yes - What and how many per day? _____

No

13. Are you on a special diet?

- Yes - What type of diet? _____
 No

14. Have you had an organ transplant or bone marrow/stem cell transplant?

- Yes
 No

If yes, what and when? _____

15. If it is possible for you to become pregnant, are you....

- Pregnant/trying to get pregnant Nursing Taking oral contraceptives

If pregnant, how many weeks and when are you due? _____

16. Are you allergic to any of the following:

- No Allergies Local Anesthetics Seasonal Allergies
 Penicillin Metals Iodine/Shellfish
 Codeine Latex Sodium Laurel Sulfate
 Sulfa Drugs Aspirin Adhesive
 Other _____

17. Have you ever had an anaphylaxis reaction or needed an epi-pen?

- Yes
 No

Do you have or have you had any of the following? Mark all that apply.

18. Chronic Infectious Diseases

AIDS/HIV positive	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No
Hepatitis C	<input type="radio"/> Yes <input type="radio"/> No	Cold sores/ Oral HPV	<input type="radio"/> Yes <input type="radio"/> No
Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No	Pneumonia	<input type="radio"/> Yes <input type="radio"/> No
Hepatitis B	<input type="radio"/> Yes <input type="radio"/> No	MRSA or VRSA	<input type="radio"/> Yes <input type="radio"/> No

19. Cardiac and Circulatory Health

Angina/chest pains	<input type="radio"/> Yes <input type="radio"/> No	Damaged heart valve	<input type="radio"/> Yes <input type="radio"/> No
High cholesterol	<input type="radio"/> Yes <input type="radio"/> No	High blood pressure	<input type="radio"/> Yes <input type="radio"/> No
Heart attack	<input type="radio"/> Yes <input type="radio"/> No	Pacemaker/Implanted device	<input type="radio"/> Yes <input type="radio"/> No
Coronary artery bypass (CABG) or other heart surgery	<input type="radio"/> Yes <input type="radio"/> No	Coronary artery disease/ Arteriosclerosis	<input type="radio"/> Yes <input type="radio"/> No
Congenital heart defect (repaired or unrepaired)	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic fever/rheumatic heart disease	<input type="radio"/> Yes <input type="radio"/> No
Arrhythmia/irregular heart beat	<input type="radio"/> Yes <input type="radio"/> No	Tachycardia (rapid heart rate)	<input type="radio"/> Yes <input type="radio"/> No
Swelling of limbs	<input type="radio"/> Yes <input type="radio"/> No	History of endocarditis	<input type="radio"/> Yes <input type="radio"/> No
Stroke	<input type="radio"/> Yes <input type="radio"/> No	Other cardiac or circulatory condition	<input type="radio"/> Yes <input type="radio"/> No
Artificial (prosthetic) heart valve	<input type="radio"/> Yes <input type="radio"/> No	Mitral valve prolapse	<input type="radio"/> Yes <input type="radio"/> No
Low blood pressure	<input type="radio"/> Yes <input type="radio"/> No	Recent carotid endarterectomy or stenting	<input type="radio"/> Yes <input type="radio"/> No
Congestive heart failure	<input type="radio"/> Yes <input type="radio"/> No	Transitory Ischemic Attack (TIA)	<input type="radio"/> Yes <input type="radio"/> No
Atrial fibrillation (Afib)	<input type="radio"/> Yes <input type="radio"/> No		

20. Respiratory Health

Asthma	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No
Cough that produces blood	<input type="radio"/> Yes <input type="radio"/> No	Persistent or frequent cough	<input type="radio"/> Yes <input type="radio"/> No
COPD	<input type="radio"/> Yes <input type="radio"/> No	Sleep Apnea	<input type="radio"/> Yes <input type="radio"/> No
Shortness of breath/ Easily winded	<input type="radio"/> Yes <input type="radio"/> No	Recent upper respiratory infection (covid, flu, cold, or RSV)	<input type="radio"/> Yes <input type="radio"/> No
Bronchitis	<input type="radio"/> Yes <input type="radio"/> No	Oxygen dependence	<input type="radio"/> Yes <input type="radio"/> No
Other breathing problem	<input type="radio"/> Yes <input type="radio"/> No		

21. Kidney and Genitourinary Health

Kidney disease	<input type="radio"/> Yes <input type="radio"/> No	Kidney failure	<input type="radio"/> Yes <input type="radio"/> No
Frequent urination	<input type="radio"/> Yes <input type="radio"/> No	STI/STD	<input type="radio"/> Yes <input type="radio"/> No
Gall or kidney stones	<input type="radio"/> Yes <input type="radio"/> No	Other kidney or genito-urinary condition	<input type="radio"/> Yes <input type="radio"/> No

22. Head, Neck, and Musculoskeletal Health

Orthopedic joint replacement (knee, hip, shoulder, etc)	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No
Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Macular degeneration	<input type="radio"/> Yes <input type="radio"/> No
Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No	Upper cervical/neck pain or care	<input type="radio"/> Yes <input type="radio"/> No
Impairment of hearing, sight, or speech	<input type="radio"/> Yes <input type="radio"/> No	Other head, neck or musculoskeletal condition	<input type="radio"/> Yes <input type="radio"/> No
Sinus problem	<input type="radio"/> Yes <input type="radio"/> No		

23. Hormone Health

Diabetes type I	<input type="radio"/> Yes <input type="radio"/> No	Diabetes type II	<input type="radio"/> Yes <input type="radio"/> No
Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Hyperthyroidism	<input type="radio"/> Yes <input type="radio"/> No
Adrenal disease such as Cushing's	<input type="radio"/> Yes <input type="radio"/> No	Grave's or Hashimoto's disease	<input type="radio"/> Yes <input type="radio"/> No
Hypothyroidism	<input type="radio"/> Yes <input type="radio"/> No	Hormone replacement therapy	<input type="radio"/> Yes <input type="radio"/> No
Other hormone deficiency or excess	<input type="radio"/> Yes <input type="radio"/> No	Gender affirming care/hormone therapy	<input type="radio"/> Yes <input type="radio"/> No
Gestational diabetes	<input type="radio"/> Yes <input type="radio"/> No	Metabolic syndrome	<input type="radio"/> Yes <input type="radio"/> No
Other hormone related condition	<input type="radio"/> Yes <input type="radio"/> No		

24. Neurological Health

Fainting spells or dizzy episodes	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy	<input type="radio"/> Yes <input type="radio"/> No
Parkinson's disease	<input type="radio"/> Yes <input type="radio"/> No	Tremors	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's disease	<input type="radio"/> Yes <input type="radio"/> No	Dementia	<input type="radio"/> Yes <input type="radio"/> No
Concussion	<input type="radio"/> Yes <input type="radio"/> No	ADHD/ADD	<input type="radio"/> Yes <input type="radio"/> No
Tourette's syndrome	<input type="radio"/> Yes <input type="radio"/> No	Cerebral Palsy	<input type="radio"/> Yes <input type="radio"/> No
Other nervous system disorder	<input type="radio"/> Yes <input type="radio"/> No	Traumatic brain injury	<input type="radio"/> Yes <input type="radio"/> No
Seizures or convulsions	<input type="radio"/> Yes <input type="radio"/> No	Autism spectrum disorder	<input type="radio"/> Yes <input type="radio"/> No
Frequent headaches or Migraines	<input type="radio"/> Yes <input type="radio"/> No	Developmental or intellectual disability	<input type="radio"/> Yes <input type="radio"/> No

25. Autoimmune Health

Crohn's disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcerative colitis	<input type="radio"/> Yes <input type="radio"/> No
Ehler's Danlos	<input type="radio"/> Yes <input type="radio"/> No	Multiple Sclerosis	<input type="radio"/> Yes <input type="radio"/> No
Chronic fatigue syndrome	<input type="radio"/> Yes <input type="radio"/> No	Rheumatoid arthritis or other inflammatory arthritis	<input type="radio"/> Yes <input type="radio"/> No
Cushing's syndrome	<input type="radio"/> Yes <input type="radio"/> No	History of cortisone medication	<input type="radio"/> Yes <input type="radio"/> No
Immune deficiency or immunocompromised	<input type="radio"/> Yes <input type="radio"/> No	POTS (postural orthopedic hypertension)	<input type="radio"/> Yes <input type="radio"/> No
Other autoimmune disorder	<input type="radio"/> Yes <input type="radio"/> No	Addison's disease	<input type="radio"/> Yes <input type="radio"/> No
Lupus	<input type="radio"/> Yes <input type="radio"/> No	Hives or rash	<input type="radio"/> Yes <input type="radio"/> No
Sjogren's syndrome	<input type="radio"/> Yes <input type="radio"/> No	Fibromyalgia	<input type="radio"/> Yes <input type="radio"/> No

26. Mental Health

Generalized anxiety	<input type="radio"/> Yes <input type="radio"/> No	Clinical depression	<input type="radio"/> Yes <input type="radio"/> No
PTSD	<input type="radio"/> Yes <input type="radio"/> No		

Are you currently being treated for any mental health condition?

- Yes: _____
- No

Do you have or have you previously been treated for drug dependency?

- Yes
- No

27. Blood Health & Conditions

Anemia	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No
Blood transfusion	<input type="radio"/> Yes <input type="radio"/> No	Sickle cell disease	<input type="radio"/> Yes <input type="radio"/> No
Other blood condition	<input type="radio"/> Yes <input type="radio"/> No	Excessive or prolonged bleeding	<input type="radio"/> Yes <input type="radio"/> No
Bruise easily	<input type="radio"/> Yes <input type="radio"/> No		

28. Stomach, Liver, Intestinal Health

Stomach Ulcer	<input type="radio"/> Yes <input type="radio"/> No	Acid Reflux/GERD	<input type="radio"/> Yes <input type="radio"/> No
Frequent vomiting	<input type="radio"/> Yes <input type="radio"/> No	Malnutrition	<input type="radio"/> Yes <input type="radio"/> No
Cirrhosis of the liver	<input type="radio"/> Yes <input type="radio"/> No	Jaundice	<input type="radio"/> Yes <input type="radio"/> No
Irritable bowel syndrome	<input type="radio"/> Yes <input type="radio"/> No	Other liver, stomach, intestinal disease	<input type="radio"/> Yes <input type="radio"/> No
Heartburn	<input type="radio"/> Yes <input type="radio"/> No	Bile duct disease	<input type="radio"/> Yes <input type="radio"/> No
Eating Disorder	<input type="radio"/> Yes <input type="radio"/> No		

29. Cancer

Cancer	<input type="radio"/> Yes <input type="radio"/> No	Chemotherapy treatment	<input type="radio"/> Yes <input type="radio"/> No
Radiation treatment	<input type="radio"/> Yes <input type="radio"/> No	Non-cancerous tumor or growth	<input type="radio"/> Yes <input type="radio"/> No

If yes to cancer, please list type of cancer, date of diagnosis, and date of treatment:

DENTAL HISTORY:

30. Do you have or have you had any of the following? Mark all that apply.

Bleeding gums	<input type="radio"/> Yes <input type="radio"/> No	Sensitivity to hot, cold, sweets, or pressure	<input type="radio"/> Yes <input type="radio"/> No
Periodontal (gum) treatment such as SRP or deep cleaning	<input type="radio"/> Yes <input type="radio"/> No	Needed to be numb for dental cleaning in the past	<input type="radio"/> Yes <input type="radio"/> No
Night guard for grinding or clenching	<input type="radio"/> Yes <input type="radio"/> No	Mandibular advancement device for snoring or sleep apnea	<input type="radio"/> Yes <input type="radio"/> No
Dental implants	<input type="radio"/> Yes <input type="radio"/> No	Oral surgery	<input type="radio"/> Yes <input type="radio"/> No
Gum graft or other periodontal surgery	<input type="radio"/> Yes <input type="radio"/> No	Trouble chewing	<input type="radio"/> Yes <input type="radio"/> No
Pain in jaw joint	<input type="radio"/> Yes <input type="radio"/> No	Dry mouth	<input type="radio"/> Yes <input type="radio"/> No
Trouble opening mouth widely	<input type="radio"/> Yes <input type="radio"/> No	History of jaw locking open or closed	<input type="radio"/> Yes <input type="radio"/> No

Bleeding gums	<input type="radio"/> Yes <input type="radio"/> No	Sensitivity to hot, cold, sweets, or pressure	<input type="radio"/> Yes <input type="radio"/> No
Bad breath	<input type="radio"/> Yes <input type="radio"/> No	Extraction (removal of teeth)	<input type="radio"/> Yes <input type="radio"/> No
History of, or current orthodontic treatment	<input type="radio"/> Yes <input type="radio"/> No	Clenching or grinding	<input type="radio"/> Yes <input type="radio"/> No
Dentures or partial dentures	<input type="radio"/> Yes <input type="radio"/> No	Dental fear or anxiety	<input type="radio"/> Yes <input type="radio"/> No
Used whitening trays or had teeth whitened	<input type="radio"/> Yes <input type="radio"/> No	Mouth breathing	<input type="radio"/> Yes <input type="radio"/> No

31. What is the reason for your dental visit today? _____

32. Are you currently in any dental pain or discomfort?

Yes

No

33. If yes, please describe

34. Do you have any sores in or around your mouth?

Yes

No

35. Name of current/most recent dentist: _____

36. Date of last dental visit: _____

37. Date of last x-rays and type: _____

38. Date of last dental cleaning: _____ Type of cleaning: _____

39. Have you ever had any problems or difficulties following dental treatment?

Yes - Explain: _____

No

40. Have you ever taken an antibiotic premedication prior to dental treatment?

Yes (Type: _____)

No

41. Have you ever had a bad or unusual reaction to dental anesthesia?

Yes

No

42. Have you ever had a severe injury to your face, teeth, or jaw?

- Yes
- No

43. Have you ever had surgery or procedures on your mouth or lips, including lip or cheek fillers or botox:

- Yes
- No

44. How often do you brush your teeth? _____

45. How often do you floss your teeth? _____

46. Do you use fluoridated toothpaste or fluoride supplements? _____

47. Please state any concerns you have about your dental care: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE

DATE