HEALTH HISTORY FOR DENTAL SERVICES

Fill Out In Blue Or Black Ink

Patient Name: ______
Patient Birthdate: ______
Patient Social Security Number: ______
Patient Address: ______
______
Patient Phone: ( )

Medication List:
______
______
______
______
______

General:

1. What is the reason for the visit today? ______
2. Have there been any changes in health in the past year? Yes No
3. Is patient under the care of a doctor? Yes No
   If yes, explain: ______
   Name of Doctor: ______
4. List all surgeries: ______
   ______
5. **Past/Current Medical History: (Circle all that apply)**
   Patient is Healthy ADHD Arthritis Artificial Joints Anemia
   Asthma Diabetes Seizures/Fainting Liver Disease/Jaundice
   Hepatitis HIV/AIDS Heart Disease High Blood Pressure
   Low Blood Pressure Tuberculosis Regular Ear Infections STDs
   Mentally Challenged Learning Disabilities Kidney/Bladder Disease
   Cancer* Other Conditions: ______
   Explain all circled: ______
   ______
   ______
   *Did patient receive chemo or radiation? Yes No
6. Has the patient ever had a serious injury to head/face/jaw? Yes No
   If yes, explain: ______
7. Has patient ever had abnormal bleeding due to injury, surgery, or having teeth pulled? Yes No
   a- Has patient received blood transfusion? Yes No
   b- Does patient have blood clotting disorders? Yes No
   If yes, explain: ______
   ______

Social History:

8. Active sports: (list name of sport or N/A) ______
9. Substance Abuse: (circle all that apply) N/A Alcohol Cocaine Meth
   Cigarettes E-Cigarettes Chewing Tobacco Synthetic Drugs
   Marijuana Pills/Medicine Other: ______
   When was the last time substance was used? ______
10. **Allergies: (Circle all that apply)**
    N/A Lidocaine Penicillin Sulfa Drugs Sedatives/Sleeping Pills
    Aspirin Iodine Codeine Latex Nickel Seasonal Allergies
    Other Medicine/Substances: ______
    ______
11. Has the patient taken any medication (Fosamax, Boniva, Actonel) for Osteoporosis or Osteopenia (Brittle Bone)? Yes No
12. a- How many sugary drinks are consumed daily? ______
    b- How much water is consumed daily? ______
13. a- How many times a day do you brush your teeth? ______
    b- How often do you floss? ______

Female Patients:

14. Are you pregnant or is there a chance you may be pregnant? Yes No
15. Are you currently on birth control? Yes No
    If yes, type of contraceptive: ______

Emergency Contact:

16. Emergency Contact: ______
    Relationship: ______
    Phone Number: ( ) ______

Additional Notes: ______
______

STATEMENT OF CONSENT FOR HEALTH SERVICES

I hereby give my consent to all visits necessary for patient ______ to receive an oral evaluation, dental treatment, follow-up maintenance treatment, transportation for services, and for the release of information of health conditions to official agencies and/or private doctors. To the best of my knowledge, the foregoing medical history questions have been accurately answered. I have been given a copy of the Department of Health's Notice of Privacy Practices.

Patient or Parent/Guardian Name: (Please Print) ______
Patient or Parent/Guardian Signature: ______ Date: ______
Dentist Signature: ______ Date: ______

Office Use Only – Health History Update

Date: MM/DD/YY	Any Changes Yes	No	Date: MM/DD/YY	Any Changes Yes	No	Date: MM/DD/YY	Any Changes Yes	No	Date: MM/DD/YY	Any Changes Yes	No