



Health History Questionnaire

Today's Date: _____

Name: _____

SS#: _____

Street Address: _____

City: _____ State: _____

Zip: _____

Phone: (home) _____ Cell: _____

Work: _____

Insurance Co: _____ **Contract ID:** _____

Subscriber DOB: _____

Date of Birth: _____ Sex: Male or Female

Occupation: _____

Emergency Contact: _____

Phone: _____

Please circle any of the following that apply:

High/Low Blood Pressure

Systemic Lupus

Epilepsy

Joint Replacement

Asthma

Neurological Disorders

Osteoporosis

Cancer/Chemo/Radiation

Seizures

Cardiovascular Disease

Reflux/Persistent Heartburn

Mental Health Disorder

Pacemaker

Gastrointestinal Disease

Migraines

Congestive Heart Failure

Liver Disease/Hepatitis

Recurrent Infections

Arteriosclerosis

Kidney Problems

Ulcers

Heart Attack

Sexually Transmitted Disease

Malnutrition

Other Congenital Heart Defects

Glaucoma

Hemophilia

Tuberculosis

Arthritis

Rheumatic Fever

Paget's Disease

AIDS or HIV Infection

Rheumatic Heart Disease

Autoimmune Disease

Anemia

Emphysema

Thyroid Problems

Stroke

Chronic Pain

Smoking

Pregnant

Controlled Substances

If you circled any of the above, please explain:

Current Medications: (include vitamins, natural or herbal preparations and/or diet supplements)

Allergies – Are you allergic to or have you had a reaction to:

Local Anesthetics	Yes/No
Aspirin	Yes/No
Penicillin or other antibiotics	Yes/No
Barbiturates, sedatives, or sleeping pills	Yes/No
Sulfa drugs	Yes/No
Codeine or other narcotics	Yes/No
Metals	Yes/No
Latex	Yes/No
Iodine	Yes/No
Other:	_____

Have you had any of the following conditions?

Artificial (prosthetic) heart valve	Yes/No
Previous Infective Endocarditis	Yes/No
Damaged valves in transplanted heart	Yes/No
Congenital heart disease (CHD)	
Unrepaired, cyanotic CHD	Yes/No
Repaired (Completely) in last 6 months	Yes/No
Repaired CHD with residual defects	Yes/No

What is the reason for your visit today? _____

How do you feel about your smile? _____

Date of your last dental exam: _____

What was done at that time? _____

Date of last dental x-rays: _____

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 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 her staff, responsible for any action they take or do not take because of errors of omissions that I may have made in the completion of this form.

Signature or Patient/Legal Guardian: _____ Date: _____