Equitas Health

Health History Form

Today's Date:

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.

Name:

Last First Middle

Date of birth:

Home Phone: *Include area code*
( )

Business/Cell Phone: *Include area code*
( )

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

Your Name Relationship

	Yes	No
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?	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐
Is your home water supply fluoridated?	☐	☐
Do you drink bottled or filtered water/	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY Are you currently experiencing dental pain or discomfort	☐	☐

	Yes	No
Do you have earaches or neck pains?	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐
Do you brux or grind your teeth?	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐
Do you wear dentures or partials?	☐	☐
Do you participate in active recreational activities?	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No
Are you now under the care of a Medical Provider?	☐	☐

Primary Care Provider: Phone: *Include area code*
( )

Address/City/State/Zip:

	Yes	No
Are you in good health?	☐	☐
Has there been any change in your general health within the past year?	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No
Have you had a serious illness, operation or been hospitalizedin the past 5 years?	☐	☐

If yes, what was the illness or problem?

	Yes	No
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

_____

_____

_____

_____

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question)

Do you wear contact lenses? Yes ☐ No ☐

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Yes ☐ No ☐
Date: _____ If yes, have you had any complications?

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? Yes ☐ No ☐

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Yes ☐ No ☐
Date Treatment began:

Do you use controlled substances (drugs)? Yes ☐ No ☐

Do you use tobacco (smoking, snuff, chew, bidis)? If so, how interested are you in stopping? Yes ☐ No ☐
(Circle one) VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? Yes ☐ No ☐
If yes, how much alcohol did you drink in the last 24 hours? _____
If yes, how much do you typically drink In a week? _____

Are you:

Pregnant? Yes ☐ No ☐
Number of weeks: _____
Taking birth control pills or hormonal replacement? Yes ☐ No ☐
Nursing? Yes ☐ No ☐

~~Allergies~~ ~~- Are you allergic to or have you had a reac~~tion to:
To all **yes** responses, specify type of reaction.

	Yes	No
Local anesthetics	☐	☐
Aspirin	☐	☐
Penicillin or other antibiotics	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Sulfa drugs	☐	☐
Codeine or other narcotics	☐	☐
Metals	☐	☐
Latex (rubber)	☐	☐
Iodine	☐	☐
Hay fever/seasonal	☐	☐
Animals	☐	☐
Food	☐	☐
Other	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No
Artificial (prosthetic) heart valve	☐	☐
Previous infective endocarditis	☐	☐
Damaged valves in transplanted heart Congenital heart disease (CHD)	☐	☐
Unrepaired, cyanotic CHD	☐	☐
Repaired (completely) in last 6 months	☐	☐
Repaired CHD with residual defects	☐	☐
Cardiovascular disease.	☐	☐
Arteriosclerosis	☐	☐
Congestive heart failure	☐	☐
Damaged heart valves	☐	☐
Heart attack	☐	☐
Heart murmur	☐	☐
Low blood pressure	☐	☐
High blood pressure	☐	☐
Other congenital heart defects	☐	☐
Mitral valve prolapse	☐	☐
Pacemaker	☐	☐
Rheumatic fever	☐	☐
Rheumatic heart disease	☐	☐
Abnormal bleeding	☐	☐
Anemia	☐	☐
Blood transfusion	☐	☐
Hemophilia	☐	☐
AIDS or HIV infection	☐	☐
Arthritis	☐	☐
Autoimmune disease	☐	☐
Rheumatoid arthritis	☐	☐
Systemic lupus erythematosus Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Sinus trouble	☐	☐
Tuberculosis	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐
Chest pain upon exertion	☐	☐
Chronic pain	☐	☐
Diabetes Type I or II	☐	☐
Eating disorder Malnutrition	☐	☐
Stomach Problems	☐	☐
G.E. Reflux/persistent heartburn	☐	☐
Ulcers	☐	☐
Thyroid problems	☐	☐
Stroke	☐	☐
Glaucoma	☐	☐
Hepatitis, jaundice or liver disease	☐	☐
Epilepsy	☐	☐
Fainting spells or seizures	☐	☐
Neurological disorders	☐	☐
Sleep disorder	☐	☐
Mental health disorders	☐	☐
Recurrent Infections Kidney problems	☐	☐
Night sweats Osteoporosis	☐	☐
Persistent swollen glands in neck	☐	☐
Severe headaches/ migraines	☐	☐
Severe or rapid weight loss	☐	☐
Sexually transmitted disease Excessive urination	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes ☐ No ☐

Name of physician or dentist making recommendation: Phone:

Do you have any disease, condition, or problem not listed above that you think I should know about? Please explain: Yes ☐ No ☐

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 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/Legal Guardian: Date:

FOR COMPLETION BY DENTIST

Comments:_____

_____

_____

_____