Health History

(Please Print)

Email Form

Name _____

DENTAL

1. Reason for today's appointment: ◯ Comprehensive Examination ◯ Emergency ◯ Consultation ◯ Other _____
2. Name of your previous dentist _____ Last Visit _____
3. Are you having pain or discomfort at this time? ☐ Yes ☐ No
4. Are you nervous or apprehensive about your dental treatment? ☐ Yes ☐ No
5. Are you unhappy about the appearance of your teeth? ☐ Yes ☐ No
6. Have you ever had a bad dental experience? ☐ Yes ☐ No
7. Have you ever had an unusual reaction to dental anesthetic? ☐ Yes ☐ No
8. Do you have or have you ever had any of the following?

Bleeding or sore gums	☐ Yes	☐ No	Loose/shifting teeth	☐ Yes	☐ No
Unpleasant taste/bad breath	☐ Yes	☐ No	Sensitivity to hot/cold/sweets	☐ Yes	☐ No
Burning tongue/lips	☐ Yes	☐ No	Sensitivity to biting or pressure	☐ Yes	☐ No
Cold/canker sores	☐ Yes	☐ No	Discolored teeth	☐ Yes	☐ No
Swelling/lumps in mouth	☐ Yes	☐ No	Food trapped between teeth	☐ Yes	☐ No
Biting lips or cheek	☐ Yes	☐ No	Complications from extractions	☐ Yes	☐ No
Difficulty opening/closing jaw	☐ Yes	☐ No	Abnormal bleeding	☐ Yes	☐ No
Sore jaw muscles	☐ Yes	☐ No	Full or partial dentures	☐ Yes	☐ No
Pain/clicking/popping of jaw	☐ Yes	☐ No	Periodontal (gum) treatment	☐ Yes	☐ No
Pain in or around ears	☐ Yes	☐ No	Orthodontic treatment (braces)	☐ Yes	☐ No
Frequent headaches	☐ Yes	☐ No	Clenching or grinding teeth	☐ Yes	☐ No
Injury to face/jaw/teeth	☐ Yes	☐ No	Laughing gas (nitrous oxide)	☐ Yes	☐ No

9. Do you brush and floss on a routine daily basis? ☐ Yes ☐ No
10. Do you use a fluoride rinse or supplement? ☐ Yes ☐ No

MEDICAL

1. Has there been any change in your general health within the past year? ☐ Yes ☐ No
2. Are you now under the care of a physician? ☐ Yes ☐ No
   If so, what is the condition? _____
3. The name, address and phone number of my physician is _____

_____

4. Have you had any serious illness within the past five (5) years? ☐ Yes ☐ No
   If so, what is the illness? _____
5. Have you been hospitalized or had an operation within the past five (5) years? ☐ Yes ☐ No
   If so, what is the reason? _____
6. Do you have or have you ever had any of the following disease or problems:
   a. Rheumatic Fever of Rheumatic Heart Disease ☐ Yes ☐ No
   b. Congenital Heart Disease ☐ Yes ☐ No
   c. Cardiovascular Disease (Heart Trouble, Heat Attack, Coronary Insufficiency, Coronary Occlusion, High/Low Blood Pressure, Arteriosclerosis, Stroke, etc.) ☐ Yes ☐ No
   d. Artificial or Replacement Heart Valves ☐ Yes ☐ No
   e. Pacemaker ☐ Yes ☐ No
   f. Heart Murmur ☐ Yes ☐ No
   g. Allergies ☐ Yes ☐ No
   h. Sinus Trouble, Asthma or Hay Fever ☐ Yes ☐ No
   i. Severe Headaches, Earaches or Loss of Hearing ☐ Yes ☐ No
   j. Hives or Skin Rash ☐ Yes ☐ No
   k. Fainting Spells, Seizures or Convulsions ☐ Yes ☐ No
   l. Diabetes ☐ Yes ☐ No
   m. Hepatitis, Jaundice, Cirrhosis or Liver Disease ☐ Yes ☐ No
   n. Arthritis or Inflammatory Rheumatism ☐ Yes ☐ No
   o. Artificial/Prosthetic Joint Replacement ☐ Yes ☐ No
   p. Ulcers, Gastritis, Colitis or other Stomach/Intestinal Conditions ☐ Yes ☐ No
   q. Kidney or Bladder Troubles ☐ Yes ☐ No
   r. Tuberculosis, Bronchitis or Emphysema ☐ Yes ☐ No
   s. Immune System Disorders (AIDS, HIV, or ARC) ☐ Yes ☐ No
   t. Sexually Transmitted Disease (Venereal Disease) ☐ Yes ☐ No

u. Glaucoma, Cataracts ☐ Yes ☐ No
v. Other (list): ☐ Yes ☐ No
7. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? ☐ Yes ☐ No
8. Have you ever tested positive to the AIDS virus? ☐ Yes ☐ No
9. Do you have any blood disorder such as anemia, leukemia or sickle cell anemia? ☐ Yes ☐ No
10. Have you had surgery or x-ray treatment for a tumor, growth or other condition? ☐ Yes ☐ No
11. Are you taking any prescription, non-prescription or street drugs/medications? ☐ Yes ☐ No
If so, explain: _____
12. Are you now taking, or have you taken in the past, any of the following:
a. Antibiotics, Anticoagulants (Blood Thinners), High Blood Pressure Medicine, Cortisone (Steroids), Tranquilizers or Antidepressants, Antihistamines, Aspirin, Insulin or Other Diabetic Medications, Digitalis or Other Heart Medications, Nitroglycerin ☐ Yes ☐ No
b. Phen-fen or any other weight reduction medication? ☐ Yes ☐ No
c. Actonel, Boniva, Fosamax, Skelid, Didronel, Aredia, Zometa, Bonefos or any other bisphosphonate drug? ☐ Yes ☐ No
d. Other Medications? (list): ☐ Yes ☐ No
13. Are you allergic or have you reacted adversely to:
a. Local Anesthetics, Penicillin, Sulfa Drugs or Other Antibiotics, Barbiturates, Sedatives or Sleeping Pills, Aspirin, Iodine, Codeine or Other Narcotics? ☐ Yes ☐ No
c. Other? (list): ☐ Yes ☐ No
14. Do you use tobacco in any form? ☐ Yes ☐ No
15. Do you use any alcohol products? ☐ Yes ☐ No
16. Are you engaged in any situation which exposes you to X-rays or other ionizing radiation? ☐ Yes ☐ No
17. Are you pregnant or do you have any reason to think you may be pregnant? ☐ Yes ☐ No
18. Are you breast feeding (Nursing) ☐ Yes ☐ No
19. Do you have PMS or problems associated with your menstrual period? ☐ Yes ☐ No
20. Are you taking birth control pills or hormone therapy? ☐ Yes ☐ No
21. Do you have any disease, condition or problem not listed above? ☐ Yes ☐ No
If so, explain: _____

PATIENT NAME _____

HEALTH QUESTIONNAIRE ACKNOWLEDGMENT AND CONSENT TO PROCEED: I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Stephen D. Haslam and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to, bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

_____ _____

Patient, Legal Guardian or Authorized Agent of Patient Date Dentist Date

SUMMARY

_____

_____

_____

_____

HISTORY UPDATE

Date _____ Change(s) ❑ Yes ❑ No _____

Date _____ Change(s) ❑ Yes ❑ No _____

Date _____ Change(s) ❑ Yes ❑ No _____

Date _____ Change(s) ❑ Yes ❑ No _____

Date _____ Change(s) ❑ Yes ❑ No _____