Precision Dental Partners
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HEALTH HISTORY FORM

Patient Name ____ **Date of Birth** _____/______/_________

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 provider appropriate care for you. This office does not use this information to discriminate.

DENTAL INFORMATION

What is the reason for your dental visit today?

	Yes	No		Yes	No
Are you having any discomfort/pain at this time? If so, please explain: ______________________________	☐	☐	Is your mouth dry?	☐	☐
			Do you have earaches or neck pains?	☐	☐
Have you ever had any serious problems associated with previous dental treatment?	☐	☐	Do you clench or grind your teeth?	☐	☐
			Do you have any clicking popping or discomfort in the jaw?	☐	☐
Do your gums bleed when you brush or floss?	☐	☐	Do you have any swellings or lumps in your mouth?	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	Do you have sores or ulcers in your mouth?	☐	☐
Are your teeth loose?	☐	☐	Do you wear dentures or partials?	☐	☐
Do you have unpleasant taste or bad breath?	☐	☐	Have you ever been treated for periodontal (gum) treatments?	☐	☐
Do you have burning sensation on your tongue and lips?	☐	☐	Have you ever had orthodontic (braces) treatments?	☐	☐
Does food or floss catch between your teeth?	☐	☐	Have you ever had a serious injury to your head or mouth?	☐	☐

MEDICAL INFORMATION

	Yes	No		Yes	No
Are you now under the care of a physician? Physician Name: Phone: ( ) Address:	☐	☐	Are you taking any prescription or over the counter medicine(s)? If so, please list all.	☐	☐
Date of last physical exam: ___________________________					
Has there been any changes in your general health within past 2 years? If yes, what condition is being treated? ____	☐	☐	Do you currently or have you ever used recreational drugs?	☐	☐
			Do you use tobacco (smoking, snuff, chew, bidis)? If so, how much per day? _________________________	☐	☐
Have you had a serious illness, operation or been hospitalized in past 5 years? If yes, what was the illness or problem? ____	☐	☐	**WOMEN ONLY**. Are you:	**Yes**	**No**
			Pregnant?	☐	☐
			If yes, number of weeks: ___________________________	☐	☐
			Taking birth control pills or hormonal replacement?	☐	☐
			Nursing?	☐	☐
Allergies- Are you allergic to or have you ever had a reaction to: (To all yes responses, specify type of reaction.)	**Yes**	**No**	**Joint Replacement.** Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Date: _____________ Any complications?	**Yes** ☐	**No** ☐
Penicillin or other antibiotics _________________________	☐	☐			
Aspirin ____	☐	☐			
Sulfa drugs _____________________________________	☐	☐	Are you taking or schedule to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease?	**Yes** ☐	**No** ☐
Barbiturates, sedatives, or sleeping pills _______________	☐	☐			
Codeine or other narcotics ___________________________	☐	☐			
Local Anesthetics _________________________________	☐	☐	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? Date Treatment began: ____________________________	**Yes** ☐	**No** ☐
Metals ____	☐	☐			
Latex (rubber) ___________________________________	☐	☐			
Iodine ____	☐	☐			
Hay fever/seasonal ______________________________	☐	☐			
Other ____	☐	☐			

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

Condition	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	☐	☐

Condition	Yes	No
Abnormal bleeding	☐	☐
AIDS or HIV infection	☐	☐
Alzheimer's disease	☐	☐
Anaphylaxis	☐	☐
Anemia	☐	☐
Angina	☐	☐
Arteriosclerosis	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Autoimmune disease	☐	☐
Blood transfusion	☐	☐
If yes, date: ___________________		
Bronchitis	☐	☐
Bruise easily	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐
Cardiovascular disease	☐	☐
Chest pain upon exertion	☐	☐
Chronic pain	☐	☐
Congestive heart failure	☐	☐
Damaged heart valves	☐	☐
Diabetes Type I or II	☐	☐
Eating disorder	☐	☐
Emphysema	☐	☐
Epilepsy	☐	☐
Excessive bleeding	☐	☐
Excessive urination	☐	☐
Fainting spells or seizures	☐	☐
G.E Reflux/persistent heartburn	☐	☐
Gastrointestinal disease	☐	☐
Glaucoma	☐	☐
Heart attack	☐	☐
Heart murmur	☐	☐
Hemophilia	☐	☐
Hepatitis, jaundice, liver disease	☐	☐
High blood pressure	☐	☐
Hypoglycemia	☐	☐
Kidney problems	☐	☐
Low blood pressure	☐	☐
Malnutrition	☐	☐
Mental health disorders	☐	☐
If yes, Specify: _______________		
Mitral valve prolapse	☐	☐
Neurological disorder	☐	☐
If yes, specify: _______________		
Night sweats	☐	☐
Osteoporosis	☐	☐
Pacemaker	☐	☐
Parathyroid disease	☐	☐
Persistent swollen glands in neck	☐	☐
Recurrent infections	☐	☐
Type of infection: ___________		
Renal Dialysis	☐	☐
Rheumatic fever	☐	☐
Rheumatic heart disease	☐	☐
Rheumatoid arthritis	☐	☐
Scarlet fever	☐	☐
Severe headaches/migraines	☐	☐
Severe or rapid weight loss	☐	☐
Sexually transmitted disease	☐	☐
Shingles	☐	☐
Sinus trouble	☐	☐
Sleep disorder	☐	☐
Stroke	☐	☐
Systemic lupus erythematosus	☐	☐
Thyroid problems	☐	☐
Tuberculosis	☐	☐
Ulcers	☐	☐

Question	Yes	No
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐
Do you have any disease, condition, or problem not listed above that you think we should know about?	☐	☐

Please explain:

I certify that I have read and understand the above that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his 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 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: ____________________

If this Health History Form is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:____________________________________ Relationship to Patient: ________________________

Signature of Dentist ____