HEALTH HISTORY

39178 10th Street West
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661.947.6201

Date: ______________________________

Name: ____
Address: ____
____
City: _________________________________ State: ______ Zip: ____________
Occupation: ____

Birth Date: ___________________________
Sex: ☐ Male ☐ Female
Height: ____________ Weight: ___________

Emergency Contact: ____
Relationship: ___________________________
Phone: ________________________________
If you are completing this form for another person, what is your relationship to this person?
Name: ________________________________ Relationship: ________________

Home Phone: __________________________
Work Phone: __________________ Ext:____
Cellular: _____________________________
Soc. Sec.: ____________________________

DENTAL INFORMATION (Signature of Responsible Party):

Yes	No	Don't Know	
☐	☐	☐	Do your gums bleed whe you brush?
☐	☐	☐	Are your teeth sensitive to cold, hot, sweets, or pressure?
☐	☐	☐	Have you had any periodontal (gum) treatments?
☐	☐	☐	Have you ever had orthodontic treatment?
☐	☐	☐	Do you have headaches, earaches or neck pains?
☐	☐	☐	Do you wear removable dental appliances?
☐	☐	☐	Have you had any serious/difficult problem associated with any previous dental treatment?

If so, explain: ____

☐ ☐ ☐ Have you had any serious/difficult problem associated with any previous dental treatment? If so, explain: ______________________________________
____
____

Date of your last dental exam: ______________
Date of last hygiene appt. _________________
Date of last dental x-rays _________________

How would you describe your current dental problem? __________________________
Family history of Periodontal Disease _____________________________________
Name of last dentist: ____
What was done at that time? ____
How do you feel about the appearance of your teeth? ____
Do you have any problems with bad breath? ____

MEDICAL INFORMATION:

Yes	No	Don't Know	
☐	☐	☐	Are you in good health?
☐	☐	☐	Has there been any changes in your health within the past year?
☐	☐	☐	Are you under the care of a physician? If so, what are the conditions being treated? ____
☐	☐	☐	Have you ever had any serious illness, operation, or been hospitalized in the past five years? If so what was the illness or problem? ________________ ____
☐	☐	☐	Have you ever taken Fen Phen?
☐	☐	☐	Do you drink soft drinks/sports drinks? If yes how many per day? ________
☐	☐	☐	Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the past week? ________ month? _________ If yes _______________# drinks per day for _____________# of years
☐	☐	☐	Are you alcohol and/or drug dependent? If so have you recieved treatment? (check one) ☐ Yes ☐ No
☐	☐	☐	Do you use drugs or other substances for recreational purposes? If yes, please list ______________________________
☐	☐	☐	Do you use tobacco (smoking or chew)? If so, how interested are you in quiting? ☐ Very ☐ Somewhat ☐ No

Date of your last exam: ________________
Physician: ____________________________
Phone: _______________________________
Address: _____________________________
____
City/State/ZIP _______________________
Physician: ____________________________
Phone: _______________________________
Address: _____________________________
____
City/State/ZIP _______________________

How many years have or did you use tobacco? ____________ How much tobacco did you use per day? ________________

Are you taking any medications? If yes, for what purposes? *(Please list below)*

Name of Drug	Purpose	Date

Are you allergic to or have you had a reaction to:	Yes	No	Don't Know
Local Anesthetics	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa Drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Latex	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Metal	☐	☐	☐
Other (specify) ____________________________________			

Please check below to indicate if you have or have had any of the following diseases or problems:

	Yes	No	Don't Know
Abnormal Bleeding	☐	☐	☐
AIDS or HIV	☐	☐	☐
Anemia	☐	☐	☐
Arthritis	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐
Asthma	☐	☐	☐
Blood transfusion? If yes, date _________	☐	☐	☐
Cancer/Chemotherapy/Radiation	☐	☐	☐
Cardiovascular diseases? If yes Please specify	☐	☐	☐
☐ Angina Pectoris			
☐ Heart Murmur			
☐ Bypass Surgery			
☐ Mitral Valve Prolapse			
☐ Pacemaker			
☐ Rheumatic fever			
☐ Artificial valves			
☐ Heart Attack Date ___________			
Chest Pain upor exertion	☐	☐	☐
Chronic Pain	☐	☐	☐
Disease, drug or radiation-induced immunosupression	☐	☐	☐
Diabetes. If yes, please specify	☐	☐	☐
☐ Type I (insulin dependent) ☐ Type II			
Dry mouth	☐	☐	☐
Eating disorder.	☐	☐	☐
If yes, please specify ____________			
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Gastrointenstinal Disease	☐	☐	☐
G.E. reflux/persistent heartburn	☐	☐	☐
High Blood Pressure	☐	☐	☐
Glaucoma	☐	☐	☐

	Yes	No	Don't Know
Hemophilia	☐	☐	☐
Hepatitis	☐	☐	☐
Jaundice or Liver Disease	☐	☐	☐
Recurent infection	☐	☐	☐
If yes, indicate type of infection ________			
Mental Health disorder	☐	☐	☐
Night Sweats/Menopausal	☐	☐	☐
Neurological disorders	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistant swollen glands	☐	☐	☐
Respiratory problems. If yes, please specify	☐	☐	☐
☐ Emhpysema			
☐ Bronchitis, etc.			
Severe headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted Disease	☐	☐	☐
Sinus Trouble	☐	☐	☐
Sores or ulcers in the mouth	☐	☐	☐
Stroke. If yes, date ________________	☐	☐	☐
Systemic Lupus Erythematosus	☐	☐	☐
Tuberculosis	☐	☐	☐
Thyroid problems	☐	☐	☐
Ulcers	☐	☐	☐
Excessive urination/thirst	☐	☐	☐
Joint replacement	☐	☐	☐
Do you have any disease not listed above that you think we should know about?	☐	☐	☐
Please explain ________________________________			
Have you ever been told you needed to premedicate before your dental appointment?	☐	☐	☐
Are you pregnant?	☐	☐	☐

I certify that I have read and understand the above. 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 because of errors or ommissions that I may have made in the completion of this form.

____ ______________________

Signature of Patient, Parent or Guardian Date

Date	Comments/Changes	Signature of Patient	Signature of Dentist
_____________	______________________________	______________________	______________________
_____________	______________________________	______________________	______________________
_____________	______________________________	______________________	______________________