Rt 14 Dentistry
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815-455-3368

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?	☐	☐	Is your mouth dry?	☐	☐
If so, please explain: _____			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?	☐	☐	Are you taking any prescription or over the counter medicine(s)?	☐	☐
Physician Name: Phone: ( )			If so, please list all.		
Address:					
Date of last physical exam: _____					
Has there been any changes in your general health within past 2 years?	☐	☐	Do you currently or have you ever used recreational drugs?	☐	☐
If yes, what condition is being treated?			Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐
_____			If so, how much per day? _____		
			WOMEN ONLY. Are you:	**Yes**	**No**
Have you had a serious illness, operation or been hospitalized in past 5 years?	☐	☐	Pregnant?	☐	☐
If yes, what was the illness or problem?			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
Penicillin or other antibiotics _____	☐	☐
Aspirin _____	☐	☐
Sulfa drugs _____	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐
Codeine or other narcotics _____	☐	☐
Local Anesthetics _____	☐	☐
Metals _____	☐	☐
Latex (rubber) _____	☐	☐
Iodine _____	☐	☐
Hay fever/seasonal _____	☐	☐
Other _____	☐	☐

Joint Replacement.	Yes	No
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐
Date: _____ Any complications?		
Are you taking or schedule to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease?	☐	☐
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: _____		

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

	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	☐	☐

	Yes	No
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	☐	☐

	Yes	No
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	☐	☐

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 _____