MODERN DENTAL CONCEPTS

Health History Form

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Your answers are for our records only and are kept confidential under HIPAA. You may be asked follow-up questions. This information is vital to your care and is never used to discriminate.

Today's Date:	Email:	Preferred contact: ☐ Cell ☐ Home ☐ Email

1. Patient Information

Last Name:		First Name:		MI:
Preferred Name:		Date of Birth:		Sex: ☐ F ☐ M ☐ Other
SS# / Patient ID:		Height:		Weight:
Address:				City:
State:	ZIP:	Home Phone:		Cell / Business Phone:
Email:		Occupation:		Employer:
Emergency Contact:		Relationship:		Phone:
If completing for another person — Your Name:			Relationship:	
Whom may we thank for referring you?				

2. Dental Information

Reason for your dental visit today:		
How do you feel about your smile?		
Former dentist:	City/State:	Date of last exam:
Date of last dental X-rays:	What was done at that time?	

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Teeth sensitive to cold, hot, sweets, or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Problems with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
Do you have earaches or neck pains?	☐	☐	☐
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 sports?	☐	☐	☐
Serious injury to your head or mouth?	☐	☐	☐
Currently experiencing dental pain or discomfort?	☐	☐	☐

3. Medical Information

Physician Name:	Phone:	City/State:

	Yes	No	DK
Now under the care of a physician? (Condition:)	☐	☐	☐
Are you in good health?	☐	☐	☐
Change in general health in the past year? (What:)	☐	☐	☐
Serious illness / operation / hospitalization in past 5 yrs? (What:)	☐	☐	☐
Taking any prescription or OTC medicine(s)?	☐	☐	☐
Do you wear contact lenses?	☐	☐	☐
Orthopedic total joint replacement? (Date/complications:)	☐	☐	☐
Antiresorptive for osteoporosis? (Fosamax, Actonel, Boniva, Reclast, Prolia)	☐	☐	☐
Since 2001, antiresorptive for bone pain/cancer? (Aredia, Zometa, XGEVA)	☐	☐	☐
Do you use controlled substances (drugs)?	☐	☐	☐
Use tobacco? (Stop? ☐ Very ☐ Somewhat ☐ Not)	☐	☐	☐
Drink alcohol? (24 hrs: / per week:)	☐	☐	☐
Advised to take antibiotics before dental treatment? (Name/phone:)	☐	☐	☐

Date of last physical exam:	List all medications, vitamins, herbal preparations & supplements:

4. Allergies

Check any you are allergic to; note the reaction where known.

☐ Local anesthetics	☐ Aspirin	☐ Penicillin / antibiotics
☐ Barbiturates / sedatives	☐ Sulfa drugs	☐ Codeine / narcotics
☐ Metals	☐ Latex (rubber)	☐ Iodine
☐ Hay fever / seasonal	☐ Animals	☐ Food

Other allergies:	Describe any reactions:

5. Medical Conditions

Check any of the following that you have or have had.

Heart & Circulation

☐ Cardiovascular disease	☐ Angina	☐ Arteriosclerosis	☐ Congestive heart failure
☐ Damaged heart valves	☐ Heart attack	☐ Heart murmur	☐ Low blood pressure
☐ High blood pressure	☐ Congenital heart defects	☐ Mitral valve prolapse	☐ Pacemaker
☐ Rheumatic fever	☐ Rheumatic heart disease		

Blood & Immune

☐ Abnormal bleeding	☐ Anemia	☐ Blood transfusion (date:)	☐ Hemophilia
☐ AIDS or HIV infection	☐ Arthritis	☐ Autoimmune disease	☐ Rheumatoid arthritis
☐ Systemic lupus (SLE)			

Respiratory

☐ Asthma	☐ Bronchitis	☐ Emphysema	☐ Sinus trouble
☐ Tuberculosis (TB)			

General & Other

☐ Cancer / Chemo / Radiation	☐ Chest pain on exertion	☐ Chronic pain	☐ Diabetes (I or II)
☐ Eating disorder	☐ Malnutrition	☐ Gastrointestinal disease	☐ Acid reflux / heartburn
☐ Ulcers	☐ Thyroid problems	☐ Stroke	☐ Glaucoma
☐ Hepatitis / jaundice / liver	☐ Epilepsy	☐ Fainting spells / seizures	☐ Neurological disorder
☐ Sleep disorder	☐ Do you snore?	☐ Mental health disorder	☐ Recurrent infections
☐ Kidney problems	☐ Night sweats	☐ Osteoporosis	☐ Swollen glands in neck
☐ Headaches / migraines	☐ Rapid weight loss	☐ Sexually transmitted disease	☐ Excessive urination

Heart conditions that may require antibiotics before dental treatment

☐ Artificial (prosthetic) heart valve	☐ Previous infective endocarditis
☐ Damaged valves in transplanted heart	☐ Unrepaired cyanotic congenital heart disease (CHD)
☐ CHD repaired in last 6 months	☐ Repaired CHD with residual defects

6. For Women

	Yes	No	DK
Are you pregnant? (Weeks:)	☐	☐	☐
Taking birth control or hormone replacement?	☐	☐	☐
Are you nursing?	☐	☐	☐

7. Anything Else?

Any disease, condition, or problem not listed above we should know about? ☐ Yes ☐ No
If yes, please explain:

8. Authorization & Acknowledgment

I certify that the information on this form is accurate. I understand the importance of a truthful health history and that my dentist and staff will rely on it in treating me. I will not hold my dentist or any staff member responsible for any action taken or not taken because of errors or omissions I have made. I will notify Modern Dental Concepts of any change in my health status. This information is kept confidential under HIPAA.

Signature of Patient / Legal Guardian:	Date:
Printed Name:	Relationship to Patient:

*For office use only — Dentist Signature:*_____ *Date:*_____ *Reviewed/Updated:*_____