



MODERN DENTAL CONCEPTS

Health History Form

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As required by law, our office adheres to written policies and procedures to protect the privacy of your information. Your answers are for our records only and will be kept confidential in accordance with HIPAA and applicable laws. You may be asked follow-up questions about your responses. This information is vital to allow us to provide appropriate care and is never used to discriminate.

Today's Date: _____ **Email:** _____

Tuberculosis Screening

Do you have any of the following? (Check "Don't Know" if unsure.)

	Yes	No	Don't Know
Active tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A persistent cough lasting more than 3 weeks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A cough that produces blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been exposed to anyone with tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered "Yes" to any of the four items above, please stop and return this form to the receptionist.

1. Patient Information

Last Name:	First Name:	MI:
Preferred Name:	Date of Birth:	
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other	SS#:	
Height:	Weight:	
Address:		
City:	State:	ZIP:
Preferred: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Email		
Home Phone:	Cell / Business Phone:	
Email:	Occupation:	
Employer:		
Emergency Contact:	Phone:	
Referred by:		

If completing this form for another person

Your Name: _____

Relationship: _____

2. Dental Information

Reason for your dental visit today: _____

How do you feel about your smile? _____

Former dentist:	City/State:
Date of last dental exam:	Date of last dental X-rays:
What was done?	

	Yes	No	Don't Know
Do your gums bleed when you brush or floss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets, or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink bottled or filtered water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any clicking, popping, or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you brux or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you participate in active recreational activities (sports)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently experiencing dental pain or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Medical Information

Physician Name:

Phone:

City/State:

	Yes	No	Don't Know
Are you now under the care of a physician? (If yes, condition:)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has there been any change in your general health within the past year? (What:)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a serious illness, operation, or hospitalization in the past 5 years? (What:)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking any prescription or over-the-counter medicine(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had an orthopedic total joint replacement? (Date: Complications:)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking/scheduled for an antiresorptive (Fosamax, Actonel, Boniva, Reclast, Prolia) for osteoporosis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Since 2001, treated with an antiresorptive (Aredia, Zometa, XGEVA) for bone pain or cancer? (Date:)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use controlled substances (drugs)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use tobacco? (Interest in stopping: <input type="checkbox"/> Very <input type="checkbox"/> Somewhat <input type="checkbox"/> Not)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcoholic beverages? (Last 24 hrs: Per week:)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has a physician/dentist recommended antibiotics before dental treatment? (Name: Phone:)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Date of last physical exam: _____

List all medications, vitamins, natural/herbal preparations, and dietary supplements:

4. Allergies

Are you allergic to, or have you had a reaction to, any of the following? For each "Yes," specify the reaction.

Allergen	Yes	No	Type of reaction
Local anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	
Barbiturates, sedatives, or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	
Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>	
Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>	
Metals	<input type="checkbox"/>	<input type="checkbox"/>	
Latex (rubber)	<input type="checkbox"/>	<input type="checkbox"/>	
Iodine	<input type="checkbox"/>	<input type="checkbox"/>	
Hay fever / seasonal	<input type="checkbox"/>	<input type="checkbox"/>	
Animals	<input type="checkbox"/>	<input type="checkbox"/>	
Food	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	<input type="checkbox"/>	

5. Medical Conditions

Please check any of the following that you have or have had.

Heart & Circulation

<input type="checkbox"/> Cardiovascular disease	<input type="checkbox"/> Angina	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Congestive heart failure
<input type="checkbox"/> Damaged heart valves	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Low blood pressure
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Congenital heart defects	<input type="checkbox"/> Mitral valve prolapse	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Rheumatic heart disease		

Blood & Immune

<input type="checkbox"/> Abnormal bleeding	<input type="checkbox"/> Anemia	<input type="checkbox"/> Blood transfusion (date:)	<input type="checkbox"/> Hemophilia
<input type="checkbox"/> AIDS or HIV infection	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Autoimmune disease	<input type="checkbox"/> Rheumatoid arthritis
<input type="checkbox"/> Systemic lupus erythematosus			

Respiratory

<input type="checkbox"/> Asthma	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Sinus trouble
<input type="checkbox"/> Tuberculosis			

General & Other

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

Heart conditions that may require antibiotics before dental treatment

<input type="checkbox"/> Artificial (prosthetic) heart valve	<input type="checkbox"/> Previous infective endocarditis
<input type="checkbox"/> Damaged valves in transplanted heart	<input type="checkbox"/> Unrepaired cyanotic congenital heart disease (CHD)
<input type="checkbox"/> CHD completely repaired in last 6 months	<input type="checkbox"/> Repaired CHD with residual defects

6. For Women

	Yes	No	Don't Know
Are you pregnant? (Number of weeks:)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking birth control pills or hormone replacement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Anything Else?

Any disease, condition, or problem not listed above that we should know about? Yes No

If yes, please explain:

8. Authorization & Acknowledgment

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and staff will rely on this information for treating me. I acknowledge that my questions, if any, have been answered to my satisfaction. I will not hold my dentist, or any member of the staff, responsible for any action taken or not taken because of errors or omissions I may have made in completing this form. I will notify Modern Dental Concepts of any change in my health status. I understand this information will be kept confidential in accordance with HIPAA.

Signature of Patient / Legal Guardian:

Date: _____

Printed Name: _____ **Relationship to Patient:** _____

For office use only — Signature of Dentist:

Date:

Reviewed/Updated: