Health History Form

Logan Dental Care

E-mail: _____ Today's Date: _____

Name: Last First Middle Home Phone: include area code ( ) Business/Cell Phone: include area code ( )

Mailing Address: _____
City State Zip

Occupation: _____ Height: _____ Weight: _____ Date of birth: _____ Sex: ☐ M ☐ F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: Cell Phone:

_____ ( ) ( ) _____
include area codes

If you are completing this form for another person, what is your relationship to that person?

Your Name _____ Relationship _____

Do you have any of the following diseases or problems: ***(Check DK if you Don't Know the answer to the question)***

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood			
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY O WEEKLY O OCCASIONALLY O			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

What is the reason for your dental visit today?

_____

How do you feel about your smile?

_____

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any 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 recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam: _____

What was done at that time?

_____

Date of last dental x-rays:

_____

Medical Information *Please mark (X) your response to indicate if you have or have had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

Physician's Name: Phone: *include area code*

_____ ( )

Address/City/State/Zip:

_____

If yes, what condition is being treated?

_____

Date of last physical exam: _____

Pharmacy Name _____

Phone ( ) _____

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

_____

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

_____

_____

_____

_____

(Check DK if you Don't Know the answer to the question)

Yes No DK

Are you taking or scheduled 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: _____

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

Date: _____ If yes, have you had any complications?

Yes No DK

Do you use controlled substances (drugs)? ☐ ☐ ☐

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ ☐ ☐

If so, how interested are you in stopping?

(Circle one) VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? ☐ ☐ ☐

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

WOMEN ONLY Are you:

Pregnant? ☐ ☐ ☐

Number of weeks: _____

Taking birth control pills or hormonal replacements? ☐ ☐ ☐

Nursing? ☐ ☐ ☐

Allergies - Are you allergic to or have you had a reaction to:

Local anesthetics _____ ☐ ☐ ☐

Aspirin _____ ☐ ☐ ☐

Penicillin or other antibiotics _____ ☐ ☐ ☐

Barbiturates, sedatives, or sleeping pills _____ ☐ ☐ ☐

Sulfa drugs _____ ☐ ☐ ☐

Codeine or other narcotics _____ ☐ ☐ ☐

Metals _____ ☐ ☐ ☐

Latex (rubber) _____ ☐ ☐ ☐

Iodine _____ ☐ ☐ ☐

Hay fever/seasonal _____ ☐ ☐ ☐

Animals _____ ☐ ☐ ☐

Food _____ ☐ ☐

Other _____ ☐ ☐ ☐

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

Yes No DK

Heart murmur ☐ ☐ ☐

Mitral valve prolapse ☐ ☐ ☐

Artificial heart valves ☐ ☐ ☐

Rheumatic fever ☐ ☐ ☐

Cardiovascular disease ☐ ☐ ☐

Angina ☐ ☐ ☐

Arteriosclerosis ☐ ☐ ☐

Congestive heart failure ☐ ☐ ☐

Coronary artery disease ☐ ☐ ☐

Damaged heart valves ☐ ☐ ☐

Heart attack ☐ ☐ ☐

Low blood pressure ☐ ☐ ☐

High blood pressure ☐ ☐ ☐

Congenital heart defects ☐ ☐ ☐

Pacemaker ☐ ☐ ☐

Rheumatic heart disease ☐ ☐ ☐

Abnormal bleeding ☐ ☐ ☐

Anemia ☐ ☐ ☐

Blood transfusion ☐ ☐ ☐

If yes, date: _____

Hemophilia ☐ ☐ ☐

AIDS or HIV infection ☐ ☐ ☐

Arthritis ☐ ☐ ☐

Autoimmune disease ☐ ☐ ☐

Yes No DK

Rheumatoid arthritis ☐ ☐ ☐

Systemic lupus erythematosus ☐ ☐ ☐

Asthma ☐ ☐ ☐

Bronchitis ☐ ☐ ☐

Emphysema ☐ ☐ ☐

Sinus trouble ☐ ☐ ☐

Tuberculosis ☐ ☐ ☐

Cancer/Chemotherapy/ Radiation Treatment ☐ ☐ ☐

Chest pain upon exertion ☐ ☐ ☐

Chronic pain ☐ ☐ ☐

Diabetes Type I or II ☐ ☐ ☐

Eating disorder ☐ ☐ ☐

Malnutrition ☐ ☐ ☐

Gastrointestinal disease ☐ ☐ ☐

G.E. Reflux/persistent heartburn ☐ ☐ ☐

Ulcers ☐ ☐ ☐

Thyroid problems ☐ ☐ ☐

Stroke ☐ ☐ ☐

Glaucoma ☐ ☐ ☐

Hepatitis, jaundice or liver disease ☐ ☐ ☐

Yes No DK

Epilepsy ☐ ☐ ☐

Fainting spells or seizures ☐ ☐ ☐

Neurological disorders ☐ ☐ ☐

If yes, Specify: _____

Sleep disorder ☐ ☐ ☐

Mental health disorders ☐ ☐ ☐

Specify: _____

Recurrent infections ☐ ☐ ☐

Type of infection: _____

Kidney problems ☐ ☐ ☐

Night sweats ☐ ☐ ☐

Osteoporosis ☐ ☐ ☐

Persistent swollen glands in neck ☐ ☐ ☐

Severe headaches/ migraines ☐ ☐ ☐

Severe or rapid weight loss ☐ ☐ ☐

Sexually transmitted disease ☐ ☐ ☐

Excessive urination ☐ ☐ ☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation: _____ Phone: _____

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐

Please explain: _____

_____

_____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

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 his/her 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/her staff, responsible for any action they take or do not take because of errors or omissions that I have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____