ADA. Health History Form

Medical Alert	Condition	Premedication	Allergies	Anaest.	Date

Name ________ Last ________ First ________ Middle ________ Home Phone ( ) ________ Business Phone ( ) ________

Address ________ P.O. Box or Mailing address ________ City ________ State ________ Zip Code: ________

Occupation ________ Height ________ Weight ________ Date of Birth ___/___/___ Sex ☐ M ☐ F

Emergency Contact ________ Relationship ________ Phone ( ) ________

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

Cell Phone:

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance to applicable laws. Please note that during your initial visit 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 provide appropriate care for you. This office does not use this information to discriminate.

Dental Information SSN: DL#:

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

How would you describe your current dental problem? ________

Date of your last dental exam ________ Date of last dental x-rays ________

What was done at that time? ________

How do you feel about the appearance of your teeth? ________

Medical Information

Yes	No	Don't Know	
☐	☐	☐	Are you in good health?
☐	☐	☐	Has there been any change in your general health within the past year?

Do you have any of the following diseases or problems: **If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.**

Yes	No	Don't Know	
☐	☐	☐	Active Tuberculosis
☐	☐	☐	Persistent cough greater than a 3 week duration
☐	☐	☐	Cough that produces blood
☐	☐	☐	Are you now under the care of a physician? If so, what is/are the condition(s) being treated? ________ Date of last physical examination ________

Physician(s) ________ NAME ________ PHONE ________ ADDRESS ________ CITY/STATE/ZIP

________ NAME ________ PHONE ________ ADDRESS ________ CITY/STATE/ZIP

Yes	No	Don't Know	
☐	☐	☐	Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, what was the illness or problem? ________
☐	☐	☐	Are you taking or have you recently taken any medicine(s) including non-presciption medicine? If so, what medicine(s) are you taking? Prescribed ________ Over the counter ________ Natural or herbal preparations ________
☐	☐	☐	Are you taking, or have you taken, any diet drugs such as Pondimin (fendluramine), Redux (dexphenfluramine) or phen-fen (phentermine)?
☐	☐	☐	Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the last 24 hours? ________ In the past month? ________ If yes, ________ # of drinks per day for ________ # of years.
☐	☐	☐	Are you alcohol and/or drug dependent? If so, have you received treatment? (Check one) ☐ Yes ☐ No
☐	☐	☐	Do you use drugs or other substances for recreational purposes? If yes, please list ________ Frequency of use (daily, weekly, etc.) ________ Number of years of recreational drug use ________
☐	☐	☐	Do you use tobacco (smoking, snuff, chew)? If so, how interested are you in stopping? (Check one) ☐ Very ☐ Somewhat ☐ Not Interested
☐	☐	☐	Do you wear contact lenses?

Allergies Are you allergic to or have you had a reaction to: (Please fill out both columns)

Yes	No	Don't Know	
☐	☐	☐	Local anesthetics
☐	☐	☐	Aspirin
☐	☐	☐	Penicillin or other antibiotics
☐	☐	☐	Barbiturates, sedatives, or sleeping pills
☐	☐	☐	Sulfa drugs
☐	☐	☐	Codeine or other narcotics
☐	☐	☐	Latex
☐	☐	☐	Iodine
☐	☐	☐	Hay fever/seasonal
☐	☐	☐	Animals
☐	☐	☐	Food (Specify) ________
☐	☐	☐	Other (Specify) ________

To yes responses, specify type of reaction ________

Please complete both sides

Yes	No	Don't Know	
(Women Only)			
☐	☐	☐	Are you pregnant?
☐	☐	☐	Nursing?
☐	☐	☐	Taking birth control pills?

Yes	No	Don't Know	
☐	☐	☐	Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If so, when was this operation done?________
☐	☐	☐	Have you had any complications or difficulties with your prosthetic joint?
☐	☐	☐	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? If so, what antibiotic and dose?

Name of physician or dentist*________________ Phone ________

NOTE TO PATIENT: A new report (July 1997) prepared and endorsed by the American Dental Association and the American Academy of Orthopaedic Surgeons has recommended that antibiotic prophylaxis before dental treatment is not indicated for most dental patients with artificial orthopedic prosthetic joints. This office will be glad to discuss this report with you and provide a copy of it to you and your orthopedic surgeon/physician.

Please (X) if you have or had any of the following diseases or problems.

Yes	No	Don't Know	
☐	☐	☐	Abnormal bleeding
☐	☐	☐	AIDS or HIV infection
☐	☐	☐	Anemia
☐	☐	☐	Arthritis
☐	☐	☐	Rheumatoid arthritis
☐	☐	☐	Asthma
☐	☐	☐	Blood transfusion If yes, date ________
☐	☐	☐	Cancer/chemotherapy/radiation treatment
☐	☐	☐	Cardiovascular disease. If yes, specify below: ○ Angina ○ Arteriosclerosis ○ Artificial heart valves ○ Coronary insufficiency ○ Coronary occlusion ○ Damaged heart valves ○ Heart attack ○ Heart murmur ○ High blood pressure ○ Inborn heart defects ○ Mitral valve prolapse ○ Pacemaker ○ Rheumatic heart disease
☐	☐	☐	Chest pain upon exertion
☐	☐	☐	Chronic pain
☐	☐	☐	Persistent diarrhea
☐	☐	☐	Disease, drug, or radiation-induced immunosurpression
☐	☐	☐	Diabetes. If yes, specify below: ○ Type I (insulin dependent) ○ Type II
☐	☐	☐	Dry mouth
☐	☐	☐	Eating disorder. If yes, specify ________
☐	☐	☐	Epilepsy
☐	☐	☐	Fainting spells or seizures
☐	☐	☐	G.E. reflux
☐	☐	☐	Glaucoma
☐	☐	☐	Hemophilia
☐	☐	☐	Hepatitis, jaundice or liver disease
☐	☐	☐	Recurrent infections Indicate type of infection ________
☐	☐	☐	Kidney problems
☐	☐	☐	Low blood pressure
☐	☐	☐	Mental health disorders. If yes, specify below: ________ ________
☐	☐	☐	Malnutrition
☐	☐	☐	Migraines
☐	☐	☐	Night sweats
☐	☐	☐	Neurological disorders. If yes, specify ________
☐	☐	☐	Osteoporosis
☐	☐	☐	Persistent swollen glands in neck
☐	☐	☐	Respiratory problems. If yes, specify below: ○ Emphysema ○ Bronchitis, etc.
☐	☐	☐	Severe headaches
☐	☐	☐	Severe or rapid weight loss
☐	☐	☐	Sexually transmitted disease
☐	☐	☐	Sinus trouble
☐	☐	☐	Sleep disorder
☐	☐	☐	Sores or ulcers in the mouth
☐	☐	☐	Stroke
☐	☐	☐	Systemic lupus erythematosus
☐	☐	☐	Thyroid problems
☐	☐	☐	Tuberculosis
☐	☐	☐	Ulcers
☐	☐	☐	Excessive urination
☐	☐	☐	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. 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 may have made in the completion of this form.

____
Signature of Patient/Legal Guardian Date

For completion by dentist

Comments on patient interview concerning health history ________

____

____

Significant findings from questionnaire or oral interview ________

____

____

Dental management considerations ________

________________ ________________
Signature of Dentist Date

Health History Update: On a regular basis the patient should be questioned about any medical history changes, date and comments notated, along with signature.

Date	Comments	Signature of patient and dentist

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