Health History Form

Patient Name: ______________________________ Date: _______________

Address: _____________________________________City: _________________ Zip Code: _________

Home Phone: ________________Cell Phone: _________________Work Phone: ___________________

Email: __________________________________

Marital Status: _______________________ __ Social Security Number: _____________________

Employer: _____________________________ Occupation: _______________________________

Employer's Address: ____

Emergency Contact: __________________________ ___ Relation: __________________________

Phone Number: _______________________________

Insurance Information:

Insured's Name: ________________________ Relation to Insured: self, spouse, child, other

Insured's date of birth: ____________ Insured's social security number: _________________

Insurance Company: ______________________ Group Number: ________________________

Insurance Company Address: ________________________ Phone Number: _______________

Whom may we thank for referring you? ____

Medical Information:

Physician's name: _______________________ Date of last visit: ________________________
Address: ____
Phone Number: _________________________

Are you in good health? Yes / No
Are you currently under the care of a physician? Yes / No
If so, please explain: ____

Have you been hospitalized or had a serious illness within the past five years? Yes / No
If so, please explain: ____

Do you have, or have you had any of the following:

Y/N Anemia
Y/N Artificial bones/joints
Y/N Artificial Valves
Y/N Asthma
Y/N Arthrtitis
Y/N Blood Transfusion
Y/N Cancer/Chemotherapy
Y/N Congenital Heart Defect
Y/N Diabetes
Y/N Difficulty Breathing
Y/N Drug/Alcohol Abuse
Y/N Emphysema
Y/N Epilepsy/Seizures
Y/N Fever Blisters/Cold sores
Y/N Heart Attack
Y/N Heart Murmur
Y/N Heart Surgery
Y/N Hemophilia/Abnormal Bleeding
Y/N Hepatitis A, B, or C
Y/N High/Low Blood Pressure
Y/N HIV/AIDS
Y/N Kidney Problems
Y/N Mitral Valve Prolapse
Y/N Pacemaker
Y/N Rheumatic Fever
Y/N Severe Headaches
Y/N Shingles
Y/N Sinus Problems
Y/N Stroke
Y/N Thyroid Problems
Y/N Tuberculosis
Y/N Have you ever taken any diet pills including Fen-Phen
Y/N Do you smoke?

For Women Only:

Y/N Are you nursing?
Y/N Are you Pregnant? Number of weeks:
Y/N Are you on birth control medication?

Please list any medical condition that you have experienced that is not listed above:

Please list all Prescription and over the counter medications you are currently taking:

Please list any medication or material that you have had an allergy or adverse reaction to: (list?)

Dental Information:

Last dentist seen:

Date of last dental exam and full mouth x-rays:

Y/N Would you like your teeth whiter?
Y/N Are you concerned about bad breath?
Y/N Are your teeth sensitive to heat or cold?
Y/N Do your gums bleed when you brush/floss?
Y/N Do you have pain or clicking in your jaw?
Y/N Do you grind or clench your teeth?
Y/N Do you require antibiotics before dental treatment?
Y/N Do you get frustrated because you always need to have teeth treated or reapired?
Y/N Does food catch between your teeth?
Y/N Have you ever had periodontal or gum disease?
Y/N Do you have frequent headaches or neckaches?
Y/N Do you snore or have sleep apnea?

Consent: ____ Date: _______________________