

Hanswirth Family Dentistry Health History Form

Medical Alert

Condition

Premedication

Allergies

Anaest.

Date

Name _____ Home Phone (____) _____ Business Phone (____) _____
Last First Middle

Address _____ City _____ State _____ Zip Code _____
PO Box or Mailing Address

Occupation _____ Height _____ Weight _____ Date of Birth _____ Sex M F

SS# _____ Emergency Contact _____ Relationship _____ Phone (____) _____

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

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with 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

Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>	Do your gums bleed when you brush?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>	Have you ever had orthodontic (braces) treatment?
<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"/>	Do you have headaches, earaches or neck pains?
<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"/>	Do you wear removable dental appliances?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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 <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <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?

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.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Active Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough greater than 3 week duration
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cough that produces blood
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you now under the care of a physician? If so, what 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 _____

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-prescription medicine? If so, what medicine(s) are you taking?
 Prescribed _____
 Over the counter _____
 Natural or herbal preparations _____

Have you taken any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?

Do you drink alcoholic beverage? If you, 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 so, 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 <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>	Local anesthetics	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>	Latex
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/seasonal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates, sedatives, or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Animals
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food (Specify) _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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?
 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 Orthopedic Surgeons recommend that antibiotic prophylaxis before dental treatment is not indicated for most dental patients with artificial orthopedic prosthetic joints 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		Yes	No	Don't Know		Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Disease, drug, or radiation-Induced immunosuppression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes, if yes, specify below: ○ Type I (Insulin dependent) ○ Type II	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, specify _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder, If yes, specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent swollen glands in neck
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory problems: if yes, specify below
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells or seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema Bronchitis, etc
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion if yes, date _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GEE. reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe headaches
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/chemotherapy/radiation treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe or rapid weight loss
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain upon exertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice or liver disease Indicate type of Infection _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sores or ulcers in the mouth
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorders If yes, specify below: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus erythematosus
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination
								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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 inquires 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 have been 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 local 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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____