CHIPS DENTAL ASSOCIATES

Health History Form

Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive, or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that 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.

Name: Last / First / Middle		Home Phone: *Include area code* ( )	Cell Phone: *Include area code* ( )
Address: Mailing address	City:	State:	Zip:
Occupation:	Height: Weight:	Date of Birth:	Sex: M F
SS#:	Emergency Contact:	Relationship:	Home Phone: ( ) *Include area code* Cell Phone: ( )
E-mail:	If you are completing this form for another person, what is your relationship to that person? Your Name		Relationship
Medical Insurance:		ID#:	Group #:
Primary Dental Guarantor:	Guarantor SS#:	DOB:	Phone:
Secondary Dental Guarantor:	Guarantor SS#:	DOB:	Phone:
Physician Name:	Physician Phone:	Pharmacy:	Pharmacy Phone:

Dental Information

For the following questions, please mark (X) as your response.

Question	Yes	No
Do you have bleeding or sore gums?	☐	☐
Have any sensitive teeth (hot/cold and/or pressure)?	☐	☐
Had previous orthodontic care or consulted an Orthodontist?	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐
Is your home water supply fluoridated?	☐	☐
Are you currently experiencing dental pain or discomfort?	☐	☐
Bite lips, cheeks, fingernails, etc?	☐	☐
Clench teeth or grind your teeth?	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐
Do you wear dentures or partials?	☐	☐
Mouth breathe when awake or asleep?	☐	☐
Do you have earaches or neck pains?	☐	☐
Do you participate in contact sports?	☐	☐
If so, do you wear a mouth guard?	☐	☐
Any reactions or allergic symptoms to novocaine?	☐	☐
Any difficult extractions in past?	☐	☐
Been informed of extra teeth?	☐	☐
Been informed of missing teeth?	☐	☐
Had an injury to chin, face, head, mouth, or teeth?	☐	☐

If yes to any of the above: please describe when, for what, by whom, how often, what type,until what age, etc.

Date of your last dental exam:

What was done at that time? ____________________

____

____

Date of last Dental x-rays: ____________________

The reason for your dental visit today? ____________________

____

Question	Yes	No
Would you like whiter teeth?	☐	☐
Would you like straighter teeth?	☐	☐
Do you have any spaces between teeth that you do not like?	☐	☐
Do you have any missing teeth you would like to replace?	☐	☐
Do you have any anxiety about having dental treatment?	☐	☐

If there was one thing you could change about your smile, what would it be? ____________________

____

Question	Yes	No
Are you now under care of a physician	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Question	Yes	No
Are you in good health?	☐	☐
Has there been any change in your general health within the past year?	☐	☐

If yes, what condition was treated?

Date of last physical exam: ____________________

Medical Information

For the following questions, please mark (X) as your response.

	Yes	No
Do you use opiates or controlled substances (drugs)	☐	☐
Have you been to Rehab?	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐
If yes, 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? ______		
Do you wear contact lenses?	☐	☐
Joint replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐
Date: ______ If yes, have you had any complications?	☐	☐
Are you taking or scheduled to begin taking either of the medication alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease	☐	☐
Since 2001, were you treated or are presently scheduled to begin treatment with the intravenous bisphosponates (Aredia or Zometa) for bone pain, hyperglycemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastic cancer?	☐	☐
Date treatment began: ______		

	Yes	No
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐
If yes, what was the illness or problem?		
Have you ever had head & neck radiation or chemotherapy?	☐	☐
Are you taking any prescription or over the counter medicine(s)?	☐	☐
If yes, please list all, including vitamins, natural or herbal preparations and/or diet supplements (If your list of medications is long, you may attach a copy of your medications listing.) :		

WOMEN ONLY Are you:

	Yes	No
Pregnant?	☐	☐
If yes, number of weeks: ______		
Taking birth-control pills or hormonal replacement?	☐	☐
Nursing?	☐	☐

Allergies - are you allergic to or have had a reaction to:
To all yes responses, specify type of reaction.

	Yes	No
Aspirin: ______	☐	☐
Penicillin or other antibiotics: ______	☐	☐
Barbituates, sedatives, or sleeping pills: ______	☐	☐
Sulfa Drugs: ______	☐	☐
Codeine or other narcotics: ______	☐	☐
Erythromycin: ______	☐	☐
Metals: ______	☐	☐
Latex (rubber): ______	☐	☐
Iodine: ______	☐	☐
Hay fever/seasonal: ______	☐	☐
Animals: ______	☐	☐
Food: ______	☐	☐
Other: ______	☐	☐

For the following questions, please mark (X) as your response.

	Y	N
Artificial (prosthetic) heart valve	☐	☐
Previous infective endocarditis	☐	☐
Damaged valves in transplanted heart	☐	☐
Congenital heart disease (CHD)	☐	☐
Repaired (completely) in last 6 months	☐	☐
Repaired CHD with residual defects	☐	☐
Unrepaired, cyanotic (CHD), Other congenital heart defects	☐	☐
Angina	☐	☐
Arteriosclerosis	☐	☐
Damaged heart valves	☐	☐
Heart murmur	☐	☐
Abnormal bleeding	☐	☐
Anemia	☐	☐
AIDS or HIV infection	☐	☐
Arthritis	☐	☐
Blood transfusion	☐	☐
If yes, date: ______		
Cardiovascular disease	☐	☐
Pacemaker	☐	☐
Congestive heart failure	☐	☐
Heart Attack	☐	☐
Mitral valve prolapse	☐	☐
Low blood pressure	☐	☐
High blood pressure	☐	☐
Hemophilia	☐	☐
Autoimmune disease	☐	☐
Rheumatoid arthritis	☐	☐
Hepatitis, Jaundice or liver disease	☐	☐
Systemic lupus erythematous	☐	☐
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	☐	☐
Crohn's Disease	☐	☐
Epilepsy	☐	☐
Fainting spells or seizures	☐	☐
Neurological disorder	☐	☐
If yes, specify: ______		
Sleep disorder	☐	☐
Mental health disorders	☐	☐
If yes, 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	☐	☐
Glaucoma	☐	☐

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 error or omissions that I make/have made in the completion of this form.

Signature of Patient/Legal Guardian:	Date:
Signature of Doctor:	Date: