Sample Patient Health History Form

Name Nickname Date

Address City State ZIP Code

Home Cell

Email

Date of Birth SS# Sex: M/F Height Weight

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be kept confidential.

1. Has there been any change in your health in the past year?	Yes	No
If yes, please list		
2. When was your last physical exam? / /		
3. Name of Primary Care Physician (PCP)		
Conditions being treated for?		
4. Have you had any serious illness, operation or hospitalization?	Yes	No
If yes, please list		
5. Do you or any other family member have a history of problems with anesthesia?	Yes	No
6. Have you had an artificial joint replacement? (knee, hip, shoulder, etc.)		
7. Are you taking or have you taken bisphosphonates for osteoporosis or chemotherapy	Yes	No
for multiple myeloma or other cancers (Fosamax, Actonel, Boniva, Reclast, Aredia, or Zometa)?		
8. Are you taking any medications?	Yes	No
If yes, please list: _____		
_____		
9. Pharmacy name/location: _____		
10. Do you have or have you had any of the following diseases or problems?		
a. Damaged heart valves, artificial valves or heart murmur?	Yes	No
b. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition?	Yes	No
i. Chest pain upon exertion?	Yes	No
ii. Shortness of breath climbing two flights of stairs?	Yes	No
iii. Do your ankles swell?	Yes	No
c. Sinus trouble?	Yes	No
d. Asthma, hay fever or seasonal allergies?	Yes	No
e. Sleep apnea?	Yes	No
f. Fainting spells or seizures?	Yes	No
g. Diabetes?	Yes	No
h. Hepatitis, jaundice or liver disease?	Yes	No

i. Thyroid problems?	Yes	No
j. Respiratory problems, emphysema, bronchitis, etc.?	Yes	No
k. Arthritis or painful, swollen joints including jaw joint (TMJ)?	Yes	No
l. Osteoporosis?	Yes	No
m. Stomach ulcer or hyperacidity?	Yes	No
n. Kidney disease?	Yes	No
o. Tuberculosis?	Yes	No
q. Persistent cough or cough that produces blood?	Yes	No
r. Persistent swollen neck glands?	Yes	No
s. Low blood pressure?	Yes	No
t. Epilepsy or neurological disorder?	Yes	No
u. Cancer?	Yes	No
11. Have you had abnormal bleeding?	Yes	No
a. Have you ever required a blood transfusion?	Yes	No
12. Do you have any blood disorder such as anemia?	Yes	No
13. Have you ever had treatment for a tumor or growth?	Yes	No
14. Have you had radiation therapy to the head, neck or jaws?	Yes	No
15. Are you allergic to or have you had a reaction to the following? *Please note the reaction.*	Yes	No
a. Local anesthesia?	Yes	No
b. Penicillin or antibiotics?	Yes	No
c. Sulfa drugs?	Yes	No
d. Barbiturates or sleeping pills?	Yes	No
e. Aspirin?	Yes	No
f. Iodine?	Yes	No
g. Codeine or other narcotics?	Yes	No
h. Latex or rubber products?	Yes	No
i. Other?	Yes	No
16. Have you ever had any serious trouble associated with previous dental treatment?	Yes	No
If yes, please explain:	Yes	No
17. Do you have any other condition or disease you think the doctor should know about?	Yes	No
If yes, please explain:	Yes	No
18. Do you smoke any type of cigarettes, cigars, marijuana or chew tobacco? Use Opioids?	Yes	No
If yes, how much per day:	Yes	No
19. How much alcohol do you drink per week? What type?		
20. Do you have a past or present chemical dependency, alcohol or emotional disorder?	Yes	No
(e.g., anxiety, depression, ADHD)		
21. Are you wearing contact lenses?	Yes	No
22. Are you wearing removable dental appliances?	Yes	No

Women

23. Are you pregnant or trying to become pregnant?	Yes	No
24. Do you have problems associated with your menstrual period?	Yes	No
25. Are you nursing?	Yes	No

Chief Dental Complaint _____

_____

_____

_____

Referring Doctor_____

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Date _____ Patient's Signature _____

Doctor's Signature _____

Dental Insurance

Primary Insurance Company _____

Address _____

_____

Insured's Name _____

Insured's Birthdate _____

Insured's Employer _____

Telephone Number _____

Group Number _____

Relationship _____

Social Security / ID number _____

Medical Insurance

Primary Insurance Company _____

Address _____

_____

Insured's Name _____

Insured's Birthdate _____

Insured's Employer _____

Telephone Number _____

Group Number _____

Relationship _____

Social Security / ID number _____