HEALTH HISTORY QUESTIONNAIRE

Name: _____ **Date:** _____

Family Doctor/Primary Care Physician's Name (*not your Dentist*): _____

Physician's Address: _____ Phone (if known): _____

Are you currently being treated by your physician? If so, for what? _____

_____

Please list any medications you currently take or are prescribed (including aspirin, herbs, or supplements):

_____

_____

Have you *ever* taken bisphosphonate medication including Fosamax, Zometa, Didronel, Boniva, or Aredia? (Usually for osteoporosis and/or some cancer treatments): _____

Are you allergic to penicillin (including amoxicillin)? _____

If yes, please describe symptoms of the allergic reaction from penicillin: _____

Have you ever had any reactions to any other drugs or medicines, including, but not limited to local anesthetic or latex or rubber? _____

Have you ever had any surgery or operation? If so, please list and date. _____

_____

Women: Are you pregnant, or possibly pregnant? _____

Please review the list of medical conditions below and check the box for any condition you have now or may have had in the past.

Severe Head Injury	☐	Sleep Apnea	☐
Heart Attack	☐	Chronic Bronchitis	☐
Chest Pain	☐	Tuberculosis (TB)	☐
High Blood Pressure	☐	Arthritis	☐
Rheumatic Fever	☐	Artificial / Prosthetic Joint(s)	☐
Other Heart Conditions	☐	Fibromyalgia	☐
Anemia / Bleeding Problems	☐	Diabetes	☐
Severe Headaches	☐	Sexually Transmitted Disease	☐
Dizzy or Fainting Spells	☐	Herpetic Virus	☐
Stroke	☐	HIV Positive	☐
Epilepsy or Seizures	☐	Enlarged Lymph Nodes / Glands	☐
Psychiatric Treatment	☐	Tumor or Cancer	☐
Panic Attacks	☐	Radiation Therapy	☐
Hepatitis	☐	Chemotherapy	☐
Allergies or Sinus Problems	☐	Do You Use Tobacco? YES NO	
Emphysema	☐	Do You Use Injectable Drugs YES NO	
Breathing Difficulties	☐	Do You Use Other Drugs? YES NO	

Please explain any checked answers above, or any medical condition(s) not previously listed:

_____

_____

NEW PATIENT REGISTRATION

PATIENT'S LAST NAME	FIRST NAME	MIDDLE NAME		

STREET ADDRESS	CITY	STATE	ZIP CODE

DATE OF BIRTH	AGE	BIRTHPLACE	SEX	MARITAL STATUS
			M F	S M D / W

SOCIAL SECURITY NUMBER	OCCUPATION	EMPLOYER	LOCATION OF EMPLOYMENT

HOME PHONE (WITH AREA CODE)	CELL PHONE (WITH AREA CODE)	WORK PHONE (WITH AREA CODE)

PREFERRED APPOINTMENT TIME/DAY	WERE YOU REFERRED TO OUR OFFICE? IF YES, BY WHOM?

PERSON RESPONSIBLE FOR ACCOUNT	RELATIONSHIP TO PATIENT	ADDRESS	CITY

STATE	ZIP CODE	INFORMATION PROVIDED BY:	DATE:

DENTAL INSURANCE INFORMATION

DENTAL INSURANCE	POLICY NUMBER	GROUP NUMBER

SUBSCRIBER'S NAME	SUBSCRIBER'S SOCIAL SECURITY NUMBER

DENTAL HISTORY

Why are you seeking dental care at this time? _____

_____

Name/address of your previous dentist: _____

When was your last visit to the dentist? _____

When was the last time you had dental x-rays taken? _____

Check any of the following which you may have:

Jaw joint clicking or popping	☐	History of wearing braces / orthodontics	☐
Jaw pain	☐	Wisdom teeth removed / missing	☐
Clinching or grinding your teeth	☐	Loose teeth	☐
Frequent headaches	☐	Missing teeth	☐
Difficulty chewing	☐	Dry mouth	☐
Teeth that are sensitive to cold	☐	History of mouth sores or blisters	☐
Teeth that are sensitive to hot	☐	White or red spots in mouth	☐
Facial swelling	☐	Snoring	☐
Bleeding gums	☐	Sleep apnea	☐

Are you unhappy with the appearance of your teeth or crowns? _____