2025 Health History Form

Patient Information

First Name
-

Middle Name
-

Last Name
-

Email
-

Home Phone
-

Business/Cell Phone
-

Address
-

City
-

State
-

ZIP Code
-

Occupation
-

Height
-

Weight
-

Date of Birth
-

Gender
-

SS# or Patient ID
-

Emergency Contact
-

Today’s 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.

Responsible Party

If you are filling out this form on behalf of another person, please mention your name and your relationship with that person

Your Name
-

Relationship
-

Dental Information

Are you currently experiencing dental pain or discomfort?
-

Do you have any clicking, popping or discomfort in the jaw?
-

Do you have sores or ulcers in your mouth?
-

What is the reason for your dental visit today?
-

Medical Information

Are you now under the care of a physician?
-

Physician Name
-

Phone
-

Are you in good health?
-

Has there been any change in your general health within the past year?
-

If yes, what condition is being treated?
-

Date of last physical exam
-

Have you had a serious illness, operation or been hospitalized in the past 5 years?
-

If yes, what was the illness or problem?
-

Are you taking or have you recently taken any prescription or over the counter medicine(s)?
-

If so, please list all, including prescriptions, vitamins, natural or herbal preparations and/or dietary supplements
-

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax® , Actonel® , Atelvia, Boniva® , Reclast, Prolia, Aredia, Zometa, XGEVA) for osteoporosis, Paget's disease, multiple myeloma or metastatic cancer?
-

Do you use controlled substances/recreational (drugs)?
-

Do you use marijuana/cannibis products?
-

Do you use tobacco (smoking, snuff, chew, bidis, vaping)?
-

Do you drink alcoholic beverages?
-

Allergies

Are you allergic to or have you had a reaction to?

If you answer YES to any of the following allergies, please specify their reaction, too.

Local anesthetics
-

Aspirin
-

Penicillin or other antibiotics
-

Barbiturates, sedatives, or sleeping pills
-

Sulfa drugs
-

Codeine or other narcotics
-

Metals
-

Latex (rubber)
-

Iodine
-

Hay fever/seasonal
-

Animals
-

Food
-

Other
-

FOR WOMEN ONLY

Are you pregnant?
-

Number of weeks
-

Taking birth control pills or hormonal replacement?
-

Are you nursing?
-

Please mark your response to indicate if you have or have not had any of the following diseases or problems

Artificial (prosthetic) heart valve
-

Previous infective endocarditis
-

Damaged valves in transplanted heart
-

Congenital heart disease (CHD)

Cardiovascular disease
-

Arteriosclerosis
-

Congestive heart failure
-

Damaged heart valves
-

Heart attack
-

Heart murmur
-

Low blood pressure
-

High blood pressure
-

Other congenital heart defects
-

Mitral valve prolapse
-

Pacemaker
-

Rheumatic fever
-

Rheumatic heart disease
-

Abnormal bleeding
-

Anemia
-

Hemophilia
-

AIDS or HIV infection
-

Arthritis
-

Autoimmune disease
-

Rheumatoid arthritis
-

Asthma
-

Bronchitis
-

Emphysema
-

Sinus trouble
-

Tuberculosis
-

Cancer/Chemotherapy/ Radiation Treatment
-

Chest pain upon exertion
-

Chronic pain
-

Diabetes Type I or II
-

Eating disorder
-

Gastrointestinal disease
-

Acid Reflux/GERD
-

Ulcers
-

Thyroid problems
-

Stroke
-

Hepatitis, jaundice or liver disease
-

Epilepsy
-

Fainting spells or seizures
-

Neurological disorders
-

If yes, specify
-

Sleep disorder
-

Do you snore?
-

Sleep apnea?
-

Mental health disorders
-

Specify
-

Kidney problems
-

Osteoporosis
-

Severe headaches/ migraines
-

Sexually transmitted disease
-

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?
-

Do you have any disease, condition, or problem not listed above that you think I should know about?
-

NOTE: Both the 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 errors or omissions that I may have made in the completion of this form.

Signature of the Patient/Legal Guardian (ESign)

Date
-

Date :

For Office Use

Assistant Signature (ESign)

Date :