

NAME: _____ **~HEALTH HISTORY FORM~**

DATE OF BIRTH: _____ OCCUPATION: _____

ADDRESS: _____

PHONE _____ SOCIAL SECURITY #: _____

FULL TIME STUDENT: YES/NO COLLEGE: _____

MEDICAL INFORMATION:

Are you currently under the care of a physician? Yes No

Physician's Name: _____ City, State: _____ Phone: _____

Are you in Good Health? Yes No

Has there by any change in your health within the past year? Yes No

If yes, what are you being treated for: _____

Date of last physical exam: _____

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

Do you have any of the following diseases or problems?

Active Tuberculosis: Yes No

Persistent Cough greater than 3 wks: Yes No

Cough that produces Blood Yes No

Been Exposed to anyone with tuberculosis: Yes No

Are you taking or schedule to begin taking:

Alendronate (Fosamax) Yes No

Risedronate (Actonel) Yes No

Intravenous Bisphosphonates (Aredia/Zometa) Yes No

Blood Thinners (Coumadin) Yes No

Are you taking or have you recently taken any prescription or over the counter medicines? Yes No

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

Allergies:

Local Anesthetics Yes No

Aspirin Yes No

Sulfa drugs Yes No

Metals Yes No

Iodine Yes No

Penicillin Yes No

Sedatives, sleeping pills, barbiturates: Yes No

Codeine or other Narcotics Yes No

Latex (Rubber) Yes No

Other: _____

Please indicate if you have:

Heart Murmur Yes No

Artificial Heart Valves Yes No

Cardiovascular Disease Yes No

AIDS or HIV Infection Yes No

Diabetes Type I or II Yes No

Heartburn Yes No

Joint Replacement Yes No

History of Seizures Yes No

Hepatitis, jaundice or liver Disease Yes No

Mitral Valve Prolapse Yes No

Rheumatic Fever Yes No

High Blood/Low Blood Pressure Yes No

Asthma Yes No

Gastrointestinal Disease Yes No

Thyroid problems Yes No

Kidney problems Yes No

Pacemaker Yes No

Cancer Yes No

Autoimmune Disease Yes No

Any Medical Condition not listed:

Has any physician/dentist recommended that you take antibiotics prior to your dental treatment Yes No

WOMEN ONLY: Are you: Pregnant: Yes / No

Taking Birth control pills: Yes / No

Number of weeks: _____

Nursing: Yes / No

DENTAL INFORMATION:

Do your gums bleed when you brush or floss? Yes No

Are your teeth sensitive to cold, hot, sweets or pressure? Yes No

Have you had any previous problems associated with previous dental treatment? Yes No

Is your home water fluoridated? Yes No

Do you brux or grind your teeth? Yes No

Have you ever had a serious injury to your head/mouth? Yes No

Do you use Tobacco products? Yes No

Is your mouth dry? Yes No

Have you any periodontal treatments? Yes No

Are you currently experiencing dental pain or discomfort? Yes No

Do you have any clicking, popping or discomfort in your jaw? Yes No

Have you ever had braces? Yes No

Do you wear Dentures/Partials Yes No

Age of dental appliance? _____

I certify that I have read and understand the above and that the information given on this form is accurate.

Signature of Patient: _____ Date: _____

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

Emergency Contact: Name: _____ Telephone: _____ Relationship: _____

THIS FORM HAS BEEN REVIEWED BY: _____ DATE: _____

~Note: It is Norwich Family Dental Associates policy to update our patient's medical history every six months~

Revised 12/2008