Health History Form

VALLEY OAK DENTAL GROUP
1507 West Yosemite Avenue
Manteca, California 95337

Name _____ Home Phone _____ Business Phone (____) _____
Last First Middle

Address _____ City _____ State _____ Zip Code _____
P.O. Box or Mailing address

Occupation _____ Height _____ Weight _____ Date of Birth ____/____/____ Sex ☐ M ☐ F

Emergency Contact _____ Relationship _____ Phone (____) _____

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

For the following questions, please (x) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit 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.

Dental Information

Yes	No	Don't Know		Yes	No	Don't Know	
☐	☐	☐	Do your gums bleed when you brush?	☐	☐	☐	Have you ever had orthodontic (braces) treatment?
☐	☐	☐	Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐	Do you have headaches, earaches or neck pains?
☐	☐	☐	Have you had any periodontal (gum) treatments?	☐	☐	☐	Do you wear removable dental appliances?
☐	☐	☐	Have you had a serious/difficult problem associated with any previous dental treatment? If so explain _____				

How would you describe your current dental problem? _____
Date of your last dental exam _____ Date of last dental x-rays _____
What was done at that time? _____
How do you feel about the appearance of your teeth? _____

Medical Information

Yes	No	Don't Know	
☐	☐	☐	Are you in good health?
☐	☐	☐	Has there been any change in your general health within the past year?

Do you have any of the following diseases or problems: If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.

☐	☐	☐	Active Tuberculosis
☐	☐	☐	Persistent cough greater than a 3 week duration
☐	☐	☐	Cough that produces blood
☐	☐	☐	Are you now under the care of a physician? If so, what is/are the condition(s) being treated? _____

_____ Date of last physical examination _____

Physician(s) _____
NAME PHONE ADDRESS CITY/STATE/ZIP

_____
NAME PHONE ADDRESS CITY/STATE/ZIP

☐	☐	☐	Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so what was the illness or problem? _____
☐	☐	☐	Are you taking or have you recently taken any medicine(s) including non-prescription medicine? If so, what medicine(s) are you taking?

Prescribed _____
Over the counter _____
Natural or herbal preparations _____

☐	☐	☐	Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (phentermine)?
☐	☐	☐	Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the last 24 hours? _____ In the past month? _____

If yes, _____ # of drinks per day for _____ # of years

☐	☐	☐	Are you alcohol and/or drug dependent? If so, have you received treatment? (Check one) ☐ Yes ☐ No
☐	☐	☐	Do you use drugs or other substances for recreational purposes? If yes, please list _____

frequency of use (daily, weekly, etc.) _____ Number of years of recreational drug use _____

☐	☐	☐	Do you use tobacco (smoking, snuff, chew)? If so, how interested are you in stopping? (Check one) ☐ Very ☐ Somewhat ☐ Not interested
☐	☐	☐	Do you wear contact lenses?

Allergies Are you allergic to or have you had a reaction to: (Please fill out both columns)

Yes	No	Don't Know		Yes	No	Don't Know	
☐	☐	☐	Local anesthetics	☐	☐	☐	Latex
☐	☐	☐	Aspirin	☐	☐	☐	Iodine
☐	☐	☐	Penicillin or other antibiotics	☐	☐	☐	Hay fever/seasonal
☐	☐	☐	Barbiturates, sedatives, or sleeping pills	☐	☐	☐	Animals
☐	☐	☐	Sulfa drugs	☐	☐	☐	Food (Specify) _____
☐	☐	☐	Codeine or other narcotics	☐	☐	☐	Other (Specify) _____

To yes responses, specify type of reaction _____

Please complete both sides

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Yes	No	Don't Know	
☐	☐	☐	Are you pregnant?
☐	☐	☐	Nursing?
☐	☐	☐	Taking birth control pills?
☐	☐	☐	Have you had a orthopedic total joint (hip, knee, elbow, finger) replacement? If so when was this operation done? _____
☐	☐	☐	Have you ever had any complications or difficulties with your prosthetic joint?

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? If so, what antibiotic and dose and what reason? _____

Name of physician or dentist* _____ Phone _____

NOTE TO PATIENT: A new report (July 1997) prepared and endorsed by the American Dental Association and the American Academy of Orthopaedic Surgeons has recommended that antibiotic prophylaxis before dental treatment is not indicated for most dental patients with artificial orthopedic prosthetic joints. This office will be glad to discuss this report with you and provide a copy of it to you and your orthopedic surgeon/physician.

Please (x) if you have or had any of the following diseases or problems.

Yes	No	Don't Know	
☐	☐	☐	Abnormal bleeding
☐	☐	☐	AIDS or HIV infection
☐	☐	☐	Anemia
☐	☐	☐	Arthritis
☐	☐	☐	Rheumatoid arthritis
☐	☐	☐	Asthma
☐	☐	☐	Blood Transfusion
			If yes, date _____
☐	☐	☐	Cancer/chemotherapy/radiation treatment
☐	☐	☐	Cardiovascular disease
			If yes, specify below:
			O Angina
			O Arteriosclerosis
			O Artificial heart valves
			O Coronary insufficiency
			O Coronary occlusion
			O Damaged heart valves
			O Heart attack
			O Heart murmur
			O High blood pressure
			O Inborn heart defects
			O Mitral valve prolapse
			O Pacemaker
			O Rheumatic heart disease
☐	☐	☐	Chest pain upon exertion
☐	☐	☐	Chronic pain
☐	☐	☐	Persistent diarrhea

Yes	No	Don't Know	
☐	☐	☐	Disease, drug, or radiation induced immunosuppression
☐	☐	☐	Diabetes, if yes, specify below:
			O Type I (insulin dependent)
			O Type II
☐	☐	☐	Dry mouth
☐	☐	☐	Eating disorder
			If yes, specify _____
☐	☐	☐	Epilepsy
☐	☐	☐	Fainting spells or seizures
☐	☐	☐	G.E. reflux
☐	☐	☐	Glaucoma
☐	☐	☐	Hemophilia
☐	☐	☐	Hepatitis, jaundice or liver disease
☐	☐	☐	Recurrent infections
			Indicate type of infection
			_____
☐	☐	☐	Kidney problems
☐	☐	☐	Low blood pressure
☐	☐	☐	Mental health disorders
			If yes, specify below:
			_____
			_____
☐	☐	☐	Malnutrition
☐	☐	☐	Migraines
☐	☐	☐	Night sweats

Yes	No	Don't Know	
☐	☐	☐	Neurological disorders
			If yes, specify _____
☐	☐	☐	Osteoporosis
☐	☐	☐	Persistent swollen glands in neck
☐	☐	☐	Respiratory problems,
			If yes, specify below:
			O Emphysema
			O Bronchitis, etc.
☐	☐	☐	Severe headaches
☐	☐	☐	Severe or rapid weight loss
☐	☐	☐	Sexually transmitted disease
☐	☐	☐	Sinus trouble
☐	☐	☐	Sleep disorder
☐	☐	☐	Sores or ulcers in the mouth
☐	☐	☐	Stroke
☐	☐	☐	Systemic lupus erythematosus
☐	☐	☐	Thyroid problems
☐	☐	☐	Tuberculosis
☐	☐	☐	Ulcers
☐	☐	☐	Excessive urination
☐	☐	☐	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. 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 Patient/Legal Guardian Date

For completion by dentist

Comments on patient interview concerning health history _____

Significant findings from questionnaire or oral interview _____

Dental management considerations _____

Signature of Dentist _____ Date _____

Health History Update: On a regular basis the patient should be questioned about any medical history changes, date and comments notated, along with signature.

Date	Comments	Signature of Patient and dentist
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____