Monument Family Dentistry

Health History Form

Name:	Today's Date:

Although dental personnel primarily treat the area inside the mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dental services you receive. Thank you for answering the following questions regarding your health history.

Email:	Cell Phone ( )	Home Phone ( )	Social Security number (- -)
Address:	City:	State:	Zip code:
Occupation:	Age:	DOB:	Gender: M F
Emergency contact:	Relationship:	Cell Phone: ( )	Home/Bus. Phone: ( )
Complete this section if you are filling out this form for another person: Your Name:		Relationship:	
Physician:	Phone: ( )		

Please write in any allergies to medications or materials along with their reactions

Allergy	Reaction

Women Only		
Are you pregnant?	Yes	No
Number of weeks: _____		
Are you taking pre-natal vitamins?	Yes	No
Are you Nursing (Breastfeeding)?	Yes	No
OB/Gyn:	Phone: ( )	

Pre-medication:

Please mark (X) in the boxes to the left if you have any of the conditions below that may require antibiotics before Dental procedures

	Total Joint Replacement **Circle all that apply:** Hip Date: _____ Knee Date: _____ Shoulder Date: _____ Jaw Date: _____	
	Congenital Heart Disease (CHD) **Circle all that apply:** Unrepaired, cyanotic / Repaired with residual defects / Repaired in last 6 months	
	Artificial Heart Valves	**For use by Dentist**
	Previous Endocarditis	**Recommended Antibiotic**
	Stents	Amoxicillin Clindamycin
	Damaged valves in transplanted Heart	

Dental Information:

Please mark (X) in the boxes to the left if you have noticed any of the following.

	Problem	**Generalized** (All over) **UR**= Upper right **UL**= Upper left **UF**= Upper Front **LR**= lower right **LL**= Lower left **LF**= Lower Front
	I am currently experiencing Pain or discomfort.	Tongue Generalized UR UF UL LR LF LL
	Teeth are sensitive.....Hot Cold Sweets Pressure	Generalized UR UF UL LR LF LL
	Food or floss catch between teeth	Generalized UR UF UL LR LF LL
	Clicking, popping or discomfort in jaw	Right side Left side
	Sores or ulcers in mouth	Tongue Generalized UR UF UL LR LF LL
	Gums bleed when brush or floss	Generalized UR UF UL LR LF LL
	Grind teeth.....Clench jaw	
	Dry mouth	

Are you satisfied with the way your teeth look, function and feel? Yes No If no, explain:

Please mark (X) in the boxes to the left if you have had any of the following treatments.

	Treatment	Location(s)
	Deep cleaning for deep pockets (Scaling and root planning)	Generalized UR UF UL LR LF LL
	Grafts.....Bone Gingival (Gum)	UR UF UL LR LF LL
	Orthodontic treatment.....Braces Invisalign	**Date:**
	Dental Implants	UR UF UL LR LF LL
	Dentures **Circle all that apply:** Complete Denture.....Upper Lower	Partial Denture.....Upper Lower

Medical Information:

Please mark (X) in the box to the left to indicate you have any of the medical problems or disorders.
In the right column, please write in any prescription medications taken for the medical problem.

	Cardiovascular
	Cardiovascular disease
	Heart Attack (MI)
	Congestive Heart Failure (CHF)
	Angina
	Arteriosclerosis
	Heart murmur
	Mitral valve prolapse
	Rheumatic Heart disease
	Pacemaker
	High Blood Pressure
	Low Blood Pressure
	Anemia
	Prolonged bleeding
	Deep Vein Thrombosis (DVT)
	Blood transfusion(s)
	Hemophilia

	Respiratory
	Asthma
	COPD / Emphysema
	Tuberculosis
	Sinus problems

	Neurological
	Stroke (CVA)
	Seizures / Epilepsy
	Fainting / dizzy spells
	Parkinson's
	Multiple Sclerosis (MS)
	ALS
	Alzheimer's
	Dementia
	Headaches / Migraines
	Fibromyalgia
	Chronic Pain

	Musculoskeletal
	Rheumatoid Arthritis
	Osteoarthritis
	Osteoporosis
	Degenerative Joint Disease
	Degenerative Disc Disease

	Gastrointestinal / Urinary
	Liver disease
	Ulcers
	Acid Reflux (GERD)
	Kidney disease
	Dialysis

	Infectious diseases
	Hepatitis B
	Hepatitis C
	Hepatitis D
	HIV / AIDS

	Endocrine
	Diabetes Type: I II
	Thyroid disease
	Hormone Replacement Therapy

	Immune System
	Recurrent infections
	Systemic Lupus Erythematosus
	Autoimmune disease - Other

Specify:

	Psychiatric
	Depression
	ADHD
	Claustrophobia

Have you ever had Cancer? Yes No	Specify below:	Circle any Treatments	
		Radiation Therapy	Date:_____
Are you in remission? Yes No	Date:_____	Chemotherapy	Date:_____

Please write in any Surgeries

Surgeries	Date

Please write in any Prescription and OTC medications you are taking including herbal supplements

Do you Smoke: Yes No	Packs/day: _____	Have you ever smoked? Yes No	Quit Date: _____
Do you Chew tobacco: Yes No	How much?	Have you ever chewed tobacco? Yes No	Quit Date: _____

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 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 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 future updates only*

Date	Specify Changes in Medical History or write none	Patient signature	Reviewed by: