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 |
|---|---|
| | |
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| | |

| 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** **Recommended Antibiotic** Amoxicillin Clindamycin |
| | Previous Endocarditis | |
| | Stents | |
| | 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** |
|---|---|
| Are you in remission? Yes No Date:_____ | Radiation Therapy Date:_____ |
| | Chemotherapy Date:_____ |

**Please write in any Surgeries**

| Surgeries | Date |
|---|---|
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**Please write in any Prescription and OTC medications you are taking including herbal supplements**

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|---|---|---|---|
| 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: |
|---|---|---|---|
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