American Aesthetic Dentistry

Health History Form (Adults)

Patient's Name: _____ Date of Birth: _____ **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. Please note that this office does not use this information to discriminate.

Do you have any of the following diseases or problems? *(Check **DK** if you don't know the answer to the question)*	**Yes**	**No**	**DK**
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3-week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answered "yes" to any of the 4 items above, please STOP and return this form to the front desk team member.

DENTAL INFORMATION

*Please mark (X) your responses to the following questions. Check **DK** if you do not know the answer to the question.*

	Yes	**No**	**DK**
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets, or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems with previous dental treatment?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
Are you currently experiencing dental pain or discomfort?	☐	☐	☐
Do you have any clicking, popping, or discomfort in the jaw(s)?	☐	☐	☐

	Yes	**No**	**DK**
Do you grind or clench your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Approximate date of last dental visit? _____

Reason for your dental visit today? _____

_____

How do you feel about your smile? _____

_____

MEDICAL INFORMATION

*Please mark (X) your responses to the following questions. Check **DK** if you do not know the answer to the question.*

	Yes	**No**	**DK**
Are you in good health?	☐	☐	☐
Has there been changes in your general health in the past year?	☐	☐	☐

If **yes**, what condition is being treated? _____

Are you under the care of a physician?	☐	☐	☐

Physician Name: _____ Phone: _____

Address: _____ City: _____

State: _____ Zip Code: _____

Date of last physical exam: _____

	Yes	**No**	**DK**
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 (OTC) medicine(s)?	☐	☐	☐

If so, please all prescription medicines, including vitamins, or natural/herbal preparations and dietary supplements: _____

Do you wear contact lenses?..... ☐ ☐ ☐	_____

*Please mark (X) your responses to the following questions. Check **DK** if you do not know the answer to the question.*

	Yes	No	DK
Artificial (prosthetic) heart valve.....	☐	☐	☐
Previous infective endocarditis.....	☐	☐	☐
Damaged valves in transplanted heart.....	☐	☐	☐
Congenital heart disease (CHD).....	☐	☐	☐
• Unrepaired, cyanotic CHD.....	☐	☐	☐
• Repaired (completely) in last 6 months.....	☐	☐	☐
• Repaired CHD with residual defects.....	☐	☐	☐
Cardiovascular disease.....	☐	☐	☐
Angina.....	☐	☐	☐
Arteriosclerosis.....	☐	☐	☐
Congestive heart failure.....	☐	☐	☐
Damaged heart valves.....	☐	☐	☐
Heart attack.....	☐	☐	☐
Heart murmur.....	☐	☐	☐
Low blood pressure (hypotension)	☐	☐	☐
High blood pressure (hypertension)	☐	☐	☐
Other congenital heart defects.....	☐	☐	☐
Mitral valve prolapse.....	☐	☐	☐
Pacemaker.....	☐	☐	☐
Rheumatic fever.....	☐	☐	☐
Rheumatic heart disease.....	☐	☐	☐
Abnormal bleeding.....	☐	☐	☐
Anemia.....	☐	☐	☐
Blood transfusion.....	☐	☐	☐
• If yes, date: _____			
Hemophilia.....	☐	☐	☐
AIDS or HIV infection.....	☐	☐	☐
Sexually transmitted disease (STD)			
• If yes, specify: _____			
Arthritis.....	☐	☐	☐
Autoimmune disease.....	☐	☐	☐

	Yes	No	DK
Rheumatoid arthritis.....	☐	☐	☐
Systemic lupus erythematosus.....	☐	☐	☐
Asthma.....	☐	☐	☐
Bronchitis.....	☐	☐	☐
Emphysema.....	☐	☐	☐
Cancer/chemotherapy/radiation treatment.....	☐	☐	☐
Diabetes type I or II.....	☐	☐	☐
Eating disorder.....	☐	☐	☐
Gastrointestinal disease/reflux.....	☐	☐	☐
Ulcers.....	☐	☐	☐
Thyroid problems.....	☐	☐	☐
Stroke.....	☐	☐	☐
Glaucoma.....	☐	☐	☐
Hepatitis, jaundice, or liver disease.....	☐	☐	☐
Epilepsy.....	☐	☐	☐
Fainting spells or seizures.....	☐	☐	☐
Neurological disorders.....	☐	☐	☐
• If yes, specify: _____			
Sleep disorder.....	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders.....	☐	☐	☐
• If yes, specify: _____			
Recurrent infections.....	☐	☐	☐
• Type of infection: _____			
Renal (kidney) problems.....	☐	☐	☐
Night sweats.....	☐	☐	☐
Osteoporosis.....	☐	☐	☐
Persistent swollen glands in neck.....	☐	☐	☐
Severe headaches/migraines.....	☐	☐	☐
Severe or rapid weight loss.....	☐	☐	☐
Excessive urination.....	☐	☐	☐

American Aesthetic Dentistry

ALLERGIES: Are you allergic to or have you had a reaction to:
(*To all **yes** responses, please specify the type of reaction*)

	Yes	No	DK
Local anesthetics: _____	☐	☐	☐
Aspirin: _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills: _____	☐	☐	☐
Sulfa drugs: _____	☐	☐	☐
Codeine or other narcotics: _____	☐	☐	☐
Penicillin or other antibiotics: _____	☐	☐	☐
Metals: _____	☐	☐	☐
Latex: _____	☐	☐	☐
Iodine: _____	☐	☐	☐
Hay fever/seasonal: _____	☐	☐	☐
Animals: _____	☐	☐	☐
Food: _____	☐	☐	☐
Other: _____	☐	☐	☐
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? _____	☐	☐	☐

Name of physician or dentist making the recommendation:

_____Phone: _____

	Yes	No	DK
Do you drink alcoholic beverages?	☐	☐	☐
If **yes,** how much alcohol did you drink in the last 24 hours? _____			
If **yes**, how much do you typically drink in a week? _____			
Do you use tobacco (cigarettes, cigars, snuff, chew)?	☐	☐	☐
If **yes,** are you interested in stopping? (*circle one*) VERY/SOMEWHAT/ NOT INTERESTED			
Do you use controlled substances (illicit drugs)?	☐	☐	☐
Women Only. Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐
Date of last menstrual period: _____			
Joint Replacement. Have you had an orthopedic total joint replacement? (hip, knee, elbow, finger)	☐	☐	☐

Do you have any other disease, condition, or problem <u>not listed</u> above that you think we should know? Please explain.

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 Patient: _____ **Date**: _____