Dental Associate Group, LLC
Where Healthy Smiles are all about YOU...

Health History Form

E-mail: 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. This office does not use this information to discriminate.

Name: (Last First Middle) Home Phone: *Include area code* ( ) Business/Cell Phone: *Include area code* ( )

Address: (Mailing address) City: State: Zip:

Occupation: Height: Weight: Date of birth: Sex: M ☐ F ☐

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: ( ) Cell Phone: ( ) *Include area codes*

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

Your Name Relationship

Do you have any of the following diseases or problems:

	Yes	No
Active Tuberculosis	☐	☐
Persistent cough greater than a 3 week duration	☐	☐
Cough that produces blood	☐	☐
Been exposed to anyone with tuberculosis	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Whom may we thank for referring you?_____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birth Date _____

Employer _____ Work Phone_____ SS# _____

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No
Are you now under the care of a physician?	☐	☐
Physician Name: Phone: *Include area code* ( )		
Address/City/State/Zip:		
Are you in good health?	☐	☐
Has there been any change in your general health within the past year?	☐	☐
If yes, what condition is being treated?		
Date of last physical exam:		

	Yes	No
Have you had a serious illness or operation in the past ?	☐	☐
If yes, what was the illness or problem?		
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐
If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:		

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Do you wear contact lenses? ..... Yes ☐ No ☐

Do you use controlled substances (drugs)? ..... Yes ☐ No ☐

Joint Replacement

Have you had an orthopedic total joint (hip, knee, elbow, finger, vertebral) replacement? ..... ☐ ☐
Date:_____ If yes, have you had any complications?_____

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? ..... ☐ ☐

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ..... ☐ ☐
Date Treatment began: _____

Do you use tobacco (smoking, snuff, chew, bidis)? ..... ☐ ☐
If so, how interested are you in stopping?
(Circle one) VERY / SOMEWHAT / NOT INTERESTED

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? _____

WOMEN ONLY Are you:

Pregnant? ..... ☐ ☐
Number of weeks: _____
Taking birth control pills or hormonal replacement? .....
Nursing? .....

Allergies - Are you allergic to or have you had a reaction to:

	Yes	No		Yes	No
Local anesthetics_____	☐	☐	Metals_____	☐	☐
Aspirin_____	☐	☐	Latex (rubber)_____	☐	☐
Penicillin or other antibiotics_____	☐	☐	Iodine_____	☐	☐
Barbiturates, sedatives, or sleeping pills_____	☐	☐	Hay fever/seasonal_____	☐	☐
Sulfa drugs_____	☐	☐	Animals_____	☐	☐
Codeine or other narcotics_____	☐	☐	Food_____	☐	☐
			Other_____	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Cardiovascular

	Yes	No
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	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No
Cardiovascular disease.	☐	☐
Angina	☐	☐
Arteriosclerosis	☐	☐
Congestive heart failure	☐	☐
Damaged heart Valves	☐	☐
Heart attack	☐	☐
Heart murmur	☐	☐
Low blood pressure	☐	☐
High blood pressure	☐	☐
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	☐	☐
Arthritis	☐	☐

	Yes	No
Autoimmune disease	☐	☐
Rheumatoid arthritis	☐	☐
Systemic lupus erythematosus	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Sinus trouble	☐	☐
Tuberculosis	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐
Chest pain upon exertion	☐	☐
Chronic pain	☐	☐
Diabetes Type I or II	☐	☐
Eating disorder	☐	☐
Malnutrition	☐	☐
Gastrointestinal disease	☐	☐
G.E. Reflux/persistent heartburn	☐	☐
Ulcers	☐	☐
Thyroid problems	☐	☐
Stroke	☐	☐
Glaucoma	☐	☐

	Yes	No
Hepatitis, jaundice or liver disease	☐	☐
Epilepsy	☐	☐
Fainting spells or seizures	☐	☐
Neurological disorders	☐	☐
If yes, specify:_____		
Sleep disorder	☐	☐
Mental health disorders	☐	☐
Specify:_____		
Recurrent Infections	☐	☐
Type of infection_____		
Kidney problems	☐	☐
Night sweats	☐	☐
Osteoporosis	☐	☐
Persistent swollen glands in neck	☐	☐
Severe headaches/ migraines	☐	☐
Severe or rapid weight loss	☐	☐
Sexually transmitted disease	☐	☐
Excessive urination	☐	☐
Renal Dialysis	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ..... ☐ ☐

Name of physician or dentist making recommendation: Phone:

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 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/Legal Guardian: Date: