

NOBEL DENTISTRY HEALTH HISTORY FORM

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. The office does not use this information to discriminate.

E-mail:	Today's Date:
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Name:	Phone:	Alt. phone:
<i>Last</i>	<i>First</i>	<i>Middle</i>
Address:	City:	State: Zip:
Occupation:	Height :	Weight:
	DOB:	Age:
	Sex: M	F O
	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
SS#	Emergency Contact:	Relationship:
	Home Phone:	Cell Phone:

Whom may we thank for referring you:

Insurance Information

Subscriber Name:	Relation to Patient:	Subscriber DOB:
Primary Insurance:	Group #	Subscriber SS#/ID#
Secondary Insurance:	Group #	Subscriber SS#/ID#
Subscriber Employer:	Phone:	
Names of other Dependents covered under this plan:		

Dental Information *Please mark (X) your responses for the following questions.*

	Yes	No		Yes	No
Do your gums bleed when you brush or floss?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweet or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>
Does food or floss catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Do you grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any orthodontic (braces) treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated?	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam:		
Do you drink bottled or filtered water?	<input type="checkbox"/>	<input type="checkbox"/>	What was done at that time?		
If yes, how often? Select one: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally			Date of last dental x-rays:		
Are you currently experiencing dental pain or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>			
What is the reason for your dental visit today?					
How do you feel about your smile?					

Medical Information *Please mark (X) your responses to the following questions.*

	Yes	No		Yes	No
Are you under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a serious illness, operation, or been hospitalized in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
Physician Name:	Phone:		If yes, what was the illness or problem?		
Address/City/State/Zip					
Are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking or have you recently taken any prescription or over the counter medicines?	<input type="checkbox"/>	<input type="checkbox"/>
Has there been any change in your health within the past year?	<input type="checkbox"/>	<input type="checkbox"/>	If so, please list all, including vitamins and supplements:		
If yes, what condition is being treated?					
Date of last physical exam?					

Medical Information Please mark (X) your responses to the following questions.

Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use controlled substances (drugs)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Joint Replacement. Have you had orthopedic total joint (hip, knee, elbow, finger) replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____ If yes, have you had any complications? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use tobacco (smoking, snuff, chew, bidis)? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, how interested are you in stopping? Select one: VERY SOMEWHAT NOT INTERESTED
Are you taking or scheduled to begin taking an antiresorptive agent (i.e., Fosamax®, Actonel®, Atelvia®, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you drink alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much alcohol did you drink in the last 24 hours? _____ If yes, how much do you typically drink in a week? _____
Since 2001, were you treated or are you presently scheduled to begin treatment with an intravenous bisphosphonate (i.e. Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications due to Paget's disease, multiple myeloma or metastatic cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No Date Treatment began: _____	WOMEN ONLY. Are you: Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, number of weeks: _____ Taking birth control pills or hormone replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No Nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies. Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction. Yes No Local anesthetics <input type="checkbox"/> Yes <input type="checkbox"/> No Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No Penicillin or other antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No Barbiturates, sedatives, or sleeping pills <input type="checkbox"/> Yes <input type="checkbox"/> No Sulfa drugs <input type="checkbox"/> Yes <input type="checkbox"/> No Codeine or other narcotics <input type="checkbox"/> Yes <input type="checkbox"/> No	Yes No Metals <input type="checkbox"/> Yes <input type="checkbox"/> No Latex (rubber) <input type="checkbox"/> Yes <input type="checkbox"/> No Iodine <input type="checkbox"/> Yes <input type="checkbox"/> No Hay Fever/Seasonal <input type="checkbox"/> Yes <input type="checkbox"/> No Animals <input type="checkbox"/> Yes <input type="checkbox"/> No Food <input type="checkbox"/> Yes <input type="checkbox"/> No Other <input type="checkbox"/> Yes <input type="checkbox"/> No
Please mark (X) your responses to indicate if you have or have not had any of the following diseases or problems.	
Yes No Artificial (prosthetic) heart valve <input type="checkbox"/> Yes <input type="checkbox"/> No Previous infective endocarditis <input type="checkbox"/> Yes <input type="checkbox"/> No Damaged valves in transplanted heart <input type="checkbox"/> Yes <input type="checkbox"/> No Congenital heart disease (CHD) Unrepaired, cyanotic CHD <input type="checkbox"/> Yes <input type="checkbox"/> No Repaired (completely) in last 6 months <input type="checkbox"/> Yes <input type="checkbox"/> No Repaired CHD with residual defects <input type="checkbox"/> Yes <input type="checkbox"/> No	Yes No Autoimmune disease <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatoid arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No Systemic lupus erythematosus .. <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No Sinus trouble <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer/Chemotherapy/ Radiation treatment <input type="checkbox"/> Yes <input type="checkbox"/> No Chest pain upon exertion <input type="checkbox"/> Yes <input type="checkbox"/> No Chronic pain <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes Type I or II <input type="checkbox"/> Yes <input type="checkbox"/> No Eating disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Malnutrition <input type="checkbox"/> Yes <input type="checkbox"/> No Gastrointestinal disease <input type="checkbox"/> Yes <input type="checkbox"/> No GE Reflux/persistent heartburn <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid problems <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Except for the conditions listed above, antibiotic prophylaxis is no longer Recommended for any other form of CHD</i>	
Yes No Cardiovascular disease <input type="checkbox"/> Yes <input type="checkbox"/> No Angina <input type="checkbox"/> Yes <input type="checkbox"/> No Arteriosclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No Congestive heart failure <input type="checkbox"/> Yes <input type="checkbox"/> No Damaged heart valves <input type="checkbox"/> Yes <input type="checkbox"/> No Heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No Heart murmur <input type="checkbox"/> Yes <input type="checkbox"/> No Low blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No Other congenital Heart defects <input type="checkbox"/> Yes <input type="checkbox"/> No	Yes No Mitral valve prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic fever <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic heart disease <input type="checkbox"/> Yes <input type="checkbox"/> No Abnormal bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No Blood transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: _____ Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No AIDS or HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of physician or dentist making recommendation: _____ Phone: _____	
Do you have any disease, condition, or problem not listed above you think I should know about? <input type="checkbox"/> Yes <input type="checkbox"/> No Please explain: _____	

NOTE: Both doctor and patient are encouraged to discuss. 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 staff member, responsible for any action they take or do not take due to errors or omissions that I have made in the completion of this form.

Signature of Patient/Legal Guardian: _____	Signature of Dentist: _____	Date: _____
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