Health History Form

NOBEL DENTAL

As required by law, our office adheres to written polices 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:

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

Address: City: State: Zip:

Occupation: Height : Weight: Date of Birth: Age: Sex: M F

SS# Emergency Contact: Relationship: Home Phone: ( ) Cell Phone: ( )

Whom may we thank for referring you:

Insurance Information

Subscriber Name: Relation to Patient: Subscriber Date of Birth:

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
Do your gums bleed when you brush or floss?	☐	☐
Are your teeth sensitive to cold, hot, sweet or pressure?	☐	☐
Does food or floss catch between your teeth?	☐	☐
Is your mouth dry?	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐
Have you ever had any orthodontic (braces) treatment?	☐	☐
Have you had any problems with previous dental treatment?	☐	☐
Is your home water supply fluoridated?	☐	☐
Do you drink bottled or filtered water?	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY		
Are you currently experiencing dental pain or discomfort?	☐	☐

	Yes	No
Do you have earaches or neck pains?	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐
Do you grind 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?	☐	☐

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

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
Are you under the care of a physician?	☐	☐
Are you in good health?	☐	☐
Has there been any change in your health within the past year?	☐	☐

Physician Name: Phone: ( )

Address/City/State/Zip

If yes, what condition is being treated?

Date of last physical exam?

	Yes	No
Have you had a serious illness, operation, or been hospitalized in the past 5 years?	☐	☐
Are you taking or have you recently taken any prescription or over the counter medicines?	☐	☐

If yes, what was the illness or problem?

If so, please list all, including vitamins and supplements:

_____

_____

_____

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

	Yes	No
Do you wear contact lenses?	☐	☐
Joint Replacement. Have you had orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐
Date: _____ If yes, have you had any complications? _____		
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?	☐	☐
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?	☐	☐
Date Treatment began: _____		

	Yes	No
Do you use controlled substances (drugs)?	☐	☐
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?	☐	☐
If so, number of weeks: _____		
Taking birth control pills or hormone replacement?	☐	☐
Nursing?	☐	☐

Allergies. Are you allergic to or have you had a reaction to: To all **yes** responses, specify type of reaction.	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 responses to indicate if you have or have not had any of the following diseases or problems.

	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		
Cardiovascular disease	☐	☐
Angina	☐	☐
Arteriosclerosis	☐	☐
Congestive heart failure	☐	☐
Damaged heart valves	☐	☐
Heart attack	☐	☐
Heart murmur	☐	☐
Low blood pressure	☐	☐
High blood pressure	☐	☐
Other congenital Heart defects	☐	☐

	Yes	No
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 erythematous	☐	☐
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	☐	☐
GE Reflux/persistent heartburn	☐	☐
Ulcers	☐	☐
Thyroid problems	☐	☐
Stroke	☐	☐
Glaucoma	☐	☐

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

	Yes	No
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 you think I should know about?	☐	☐
Please explain:		

NOTE: Both doctor and patient are encouraged to discuss and 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 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 Gaurdian:	Signature of Dentist:	Date:

Date	Change in Health		Medication		Last Physical	Signature/Comments
	Yes	No	Yes	No		