HEALTH HISTORY FORM

E-mail: Today's Date:

As required by law, our clinic 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 clinic does not use this information to discriminate.

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

( ) ( ) ( )

Address: **City:** **State:** **Zip:**

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

Emergency Contact: **Relationship:** **Home Phone:** *Include area code* **Cell Phone:** *Include area code*

( ) ( )

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

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes No DK		Yes No DK
Do your gums bleed when you brush or floss? ……..	☐ ☐ ☐	**Do you brux or grind your teeth? ……**	☐ ☐ ☐
Is your mouth dry? ……	☐ ☐ ☐	**Do you have sores or ulcers in your mouth?.....**	☐ ☐ ☐
Have you had any problems associated with previous dental treatment? ……..	☐ ☐ ☐	**Do you wear dentures or partials? ……..**	☐ ☐ ☐
Are you currently experiencing dental pain or discomfort? ……	☐ ☐ ☐	**Have you ever had a serious injury to your head or mouth? ..**	☐ ☐ ☐
Do you have dental implants? …… Where?.....	☐ ☐ ☐	**Date of last dental exam:**	**Dentist Name & Address:**
Do you have any clicking, popping, or discomfort in the jaw? ..	☐ ☐ ☐	**Date of last dental x-rays:**	

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

Physician Name:	***Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?*** ……...Yes☐ No ☐ DK ☐
Physician Phone: include area code ***( )***	***Name of physician or dentist making recommendation:***
Physician Address / City / State / Zip Code:	**Joint Replacement:** Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?.....Yes☐ No ☐ DK ☐ Date: _____Have you had any complications?_____
Date of last physical exam:	Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?.....Yes☐ No ☐ DK ☐
What condition is being treated:	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?.....Yes☐ No ☐ DK ☐ Date Treatment began:_____
List any serious illness, operations or hospitalizations in the past 5 years:	***WOMEN ONLY*** **ARE YOU:** Pregnant?..... Yes☐ No ☐ DK ☐ Number of weeks/trimester:_____ Taking birth control pills? …….. Yes☐ No ☐ DK ☐ Taking hormonal replacement?..... Yes☐ No ☐ DK ☐ Nursing?..... Yes☐ No ☐ DK ☐

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

ALLERGIES- *Are you allergic to or have you had a reaction to: To all **YES** responses specify type of reaction.*

Allergies and Reaction	Yes	No	DK	***Allergies and Reaction***	Yes	No	DK
Local anesthetics	☐	☐	☐	**Latex (rubber)**	☐	☐	☐
Penicillin	☐	☐	☐	**Iodine**	☐	☐	☐
Other Antibiotics	☐	☐	☐	**Hay fever/seasonal**	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐	**Red Dye**	☐	☐	☐
Sulfa Drugs	☐	☐	☐	**Animals**	☐	☐	☐
Codeine	☐	☐	☐	**Food**	☐	☐	☐
Other Narcotics	☐	☐	☐	**Gluten**	☐	☐	☐
Metals	☐	☐	☐	**Other Allergies**	☐	☐	☐

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

Except for the conditions listed here, antibiotic prophylaxis is no longer recommended for any other form of CHD.	Yes	No	DK	***Except for the conditions listed here, antibiotic prophylaxis is no longer recommended for any other form of CHD.***	Yes	No	DK
Artificial (prosthetic) heart valve ……..	☐	☐	☐	Congenital heart disease (CHD) ……	☐	☐	☐
Previous infective endocarditis ……..	☐	☐	☐	Unrepaired, cyanotic CHD ……..	☐	☐	☐
Damaged valves in transplanted heart ……	☐	☐	☐	Repaired (completely) in last 6 months ……..…	☐	☐	☐
Pacemaker ……	☐	☐	☐	Repaired CHD with residual defects ……..….	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems	Yes	No	DK	***Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems***	Yes	No	DK
Cardiovascular disease ……..	☐	☐	☐	Diabetes type I or II ……..	☐	☐	☐
Angina ……..	☐	☐	☐	Eating disorder ……..	☐	☐	☐
Arteriosclerosis ……....	☐	☐	☐	Malnutrition …….....	☐	☐	☐
Congestive heart failure ……	☐	☐	☐	Gastrointestinal disease ……	☐	☐	☐
Heart attack …….....	☐	☐	☐	Reflux ……...	☐	☐	☐
Heart murmur ……..	☐	☐	☐	Persistent heartburn ……	☐	☐	☐
Low blood pressure ……	☐	☐	☐	Ulcers ……..	☐	☐	☐
High blood pressure ……	☐	☐	☐	Thyroid problems……...Hypo or Hyper ……	☐	☐	☐
Mitral valve prolapse ……..	☐	☐	☐	Stroke ……..	☐	☐	☐
Pacemaker……	☐	☐	☐	Glaucoma ……	☐	☐	☐
Rheumatic fever……..	☐	☐	☐	Hepatitis…….A…. B…. C…. D……..	☐	☐	☐
Rheumatic heart disease ……..	☐	☐	☐	Jaundice or liver disease ……..	☐	☐	☐
Abnormal bleeding ……..	☐	☐	☐	Epilepsy/Seizures ……..	☐	☐	☐
Anemia ……..	☐	☐	☐	If yes, date of last seizure			
Blood transfusion ……	☐	☐	☐	Neurological disorders……..	☐	☐	☐
If yes, date				If yes, please specify			
Hemophilia …….....	☐	☐	☐	Mental health disorder ……..….	☐	☐	☐
AIDS or HIV infection ……..	☐	☐	☐	If yes, please specify			
Autoimmune disease ……..	☐	☐	☐	Kidney failure……..	☐	☐	☐
Arthritis ……..	☐	☐	☐	If yes, Dialysis?			
Rheumatoid arthritis ……	☐	☐	☐	Organ transplant ……	☐	☐	☐
Systemic lupus erythematous ……..	☐	☐	☐	Osteoporosis ……	☐	☐	☐
Inhalant dependent asthma ……..	☐	☐	☐	Persistent swollen glands in neck ……..	☐	☐	☐
Emphysema ……	☐	☐	☐	Severe headaches/migraines ……	☐	☐	☐
Sinus trouble ……..	☐	☐	☐	Severe/rapid weight loss ……..	☐	☐	☐
Chest pain upon exertion ……..	☐	☐	☐	Sexually transmitted disease ……..….	☐	☐	☐
Radiation Treatment ……..	☐	☐	☐	Excessive urination ……..….	☐	☐	☐
Shunt or port ……..	☐	☐	☐	***Do you have any disease, condition, or problem not listed above that you think I should know about?***			

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 the STC Dental Hygiene Clinic 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 STC Dental Hygiene Clinic, or any STC instructional staff member, 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:

Patient ASA Classification I II III IV V