



Confidential Health History Form Instructions for the Dental Practice

This form should be completed by each new patient or a new patient's legal guardian. Additionally, it should be reviewed at least every six months and completed every two years by active patients. This form provides the practice a comprehensive report of a patient's health history, including essential dental health history information. The form can be completed at the start of a patient's appointment or prior to the appointment as long as the information is still current when the patient presents. Each health care provider should review the form in advance of treating the patient. Be certain to allow time in your schedule for this review.

Certain areas of medical information bear confidentiality restrictions:

- The release of mental health information requires the written authorization of both the patient and the physician or other professional person in charge of the patient.
- The release of drug and alcohol abuse records may only be released without patient authorization pursuant to a court order (not a subpoena).
- The release of HIV/AIDS status requires the written authorization of the patient that specifically authorizes disclosure of that status.
- Pregnancy of a minor cannot be released to the parent or guardian without the minor's permission.

Confidential Health History

Patient Name: _____ Date of Birth: _____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
If NO, explain: _____
2. Yes / No Has there been a change in your health within the last year?
If YES, explain: _____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
If YES, explain: _____
4. Yes / No Are you being treated by a physician now? If YES, explain: _____
Date of last medical exam? _____ Reason for exam: _____
5. Yes / No Have you had problems with prior dental treatment?
If YES, explain: _____
Date of last dental exam: _____ Name of last treating dentist: _____
6. Yes / No Are you in pain now?
If YES, explain: _____

II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

- | | | |
|---|-----------------------------------|----------------------------------|
| Yes / No Chest pain (angina) | Yes / No Blood in stools | Yes / No Frequent vomiting |
| Yes / No Fainting spells | Yes / No Diarrhea or constipation | Yes / No Jaundice |
| Yes / No Recent significant weight loss | Yes / No Frequent urination | Yes / No Dry mouth |
| Yes / No Fever | Yes / No Difficulty urinating | Yes / No Excessive thirst |
| Yes / No Night sweats | Yes / No Ringing in ears | Yes / No Difficulty swallowing |
| Yes / No Persistent cough | Yes / No Headaches | Yes / No Swollen ankles |
| Yes / No Coughing up blood | Yes / No Dizziness | Yes / No Joint pain or stiffness |
| Yes / No Bleeding problems | Yes / No Blurred vision | Yes / No Shortness of breath |
| Yes / No Blood in urine | Yes / No Bruise easily | Yes / No Sinus problems |
- Other: _____

III. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

- | | | |
|--|--|-------------------------------------|
| Yes / No Heart disease | Yes / No AIDS/HIV | Yes / No Psychiatric care |
| Yes / No Family history of heart disease | Yes / No Surgeries | Yes / No Osteoporosis |
| Yes / No Heart attack | Yes / No Hospitalization | Yes / No Thyroid disease |
| Yes / No Artificial joint | Yes / No Diabetes | Yes / No Asthma |
| Yes / No Stomach problems or ulcers | Yes / No Family history of diabetes | Yes / No Hepatitis |
| Yes / No Heart defects | Yes / No Tumors or cancer | Yes / No Sexual transmitted disease |
| Yes / No Heart murmurs | Yes / No Chemotherapy | Yes / No Herpes |
| Yes / No Rheumatic fever | Yes / No Radiation | Yes / No Canker or cold sores |
| Yes / No Skin disease | Yes / No Arthritis, rheumatism | Yes / No Anemia |
| Yes / No Hardening of arteries | Yes / No Emphysema or other lung disease | Yes / No Liver disease |
| Yes / No High blood pressure | Yes / No Kidney or bladder disease | Yes / No Eye disease |
| Yes / No Seizures | Yes / No Stroke | Yes / No Transplants |
| Yes / No Cosmetic surgery | Yes / No Eating disorders | Yes / No Tuberculosis |
- Other: _____

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?

(Please circle Yes or No for each)

- | | | |
|--|------------------------------------|-------------------------------------|
| Yes / No Aspirin | Yes / No Valium or other sedatives | Yes / No Codeine or other narcotics |
| Yes / No Penicillin or other antibiotics | Yes / No Latex | Yes / No Food |
| Yes / No Nitrous oxide | Yes / No Local anesthetic | Yes / No Metal |

Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?

(Please circle Yes or No for each)

- | | | |
|-------------------------------------|-----------------------------------|----------------------|
| Yes / No Recreational drugs | Yes / No Tobacco in any form | Yes / No Antibiotics |
| Yes / No Over-the-counter medicines | Yes / No Alcohol | Yes / No Supplements |
| Yes / No Weight loss medications | Yes / No Bisphosphonate (Fosamax) | Yes / No Aspirin |
| Yes / No Anti-Depressants | Yes / No Herbal Supplements | |

Please list all prescription medications: _____

VI. WOMEN ONLY (Please circle Yes or No for each)

- Yes / No Are you or could you be pregnant? If YES, what month? _____
- Yes / No Are you nursing? _____
- Yes / No Are you taking birth control pills? _____

VII. ALL PATIENTS (Please circle Yes or No for each)

- Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____
- Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: _____
- Yes / No Have you ever taken Fen-Phen? If YES, when: _____
- Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

Whom would you like us to contact in case of an emergency?

Name: _____ **Relationship:** _____ **Phone Number:** _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian)

Date

Signature of Dentist

Date

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____