Health History Form

Dr. Harrison & Tucker
Family Dentistry
Milan, TN

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:		City:	State:	Zip:
Occupation:	Date of Birth:		Sex: M F	
SS#:	Emergency Contact:	Relationship:	Home Phone: Include area code ( )	Cell Phone: Include area code ( )
If you are completing this from for another person, what is your relationship to that person? Your Name Relationship		Who may we thank for referring you to our office?		

Dental Information

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

Are you currently experiencing detal pain or discomfort? Yes ☐ No ☐	Date of your last dental exam:
	Date of last dental cleaning:
What is the reasaon for your dental visit today?	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.

Question	Yes	No
Are you now under the care of a physician?	☐	☐

Physician Name:

Phone: Include area code ( )

Address/City/State/Zip:

Question	Yes	No
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:

Question	Yes	No
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐

If yes, what was the illness or problem?

Question	Yes	No
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 dietary supplements:

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Form S500

Medical Information

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

Question	Yes	No
Do you take Blood Thinner (aspirin)?	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip,knee,elbow,finger) 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 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?	☐	☐
Number of weeks: __________		
Taking birth control pills or hormonal replacement?	☐	☐
Nursing?	☐	☐

Allergies. Are you allergic to or have you had a reaction to any of the following: To all yes reponses, specify type of reaction.

Allergy	Reaction	Yes	No
Local anesthetics	______	☐	☐
Aspirin	______	☐	☐
Penicillin or other antibiotics	______	☐	☐
Codeine or other narcotics	______	☐	☐
Metals	______	☐	☐
Latex (rubber)	______	☐	☐
Other:	______	☐	☐

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

Condition	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.

Condition	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	☐	☐
Autoimmune disease	☐	☐
Rheumatioid arthritis	☐	☐
Systemic lupus erythematosus	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Tuberculosis	☐	☐
Cancer/Chemotherapy	☐	☐
Radiation Treatment ______		
Type & Diagnose Date ______		
Melanoma	☐	☐
Chronic pain	☐	☐
Diabetes Type I or II	☐	☐
Gastrointestinal disease	☐	☐
G.E. Reflux/persistent heartburn	☐	☐
Ulcers	☐	☐
Stroke	☐	☐
Hepatitis, jaundice or liver disease	☐	☐
Epilepsy	☐	☐
Fainting spells or seizures	☐	☐
Neurological disorders	☐	☐
if yes, specify: ______		
Osteoporosis	☐	☐
Mental health disorders	☐	☐
Recurrent Infections	☐	☐
Type of infection: ______		
Kidney problems	☐	☐
Persistent swollen glands in neck	☐	☐

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

Question	Yes	No
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: