Health History Questionnaire

To assist us in serving you, please complete the following confidential form.

Patient's name ___________________________________ AGE:__________ Birth Date:___________

If minor, legal guardian ______________________________

Occupation _______________________________________ ❑ Married ❑ Unmarried ❑ Divorced ❑ Single

Contact in the case of emergency:________________________________

Do you have or have you had any of the following in your lifetime?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Chest pain
- ❑ Heart murmur, mitral valve prolapse, heart valve, or heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joints ❑ Knee ❑ Shoulder ❑ Hip ❑ Other
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease or stones
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Epilepsy, seizures, tremors, or fainting spells
- ❑ Stroke or TIA
- ❑ Glaucoma
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Asthma
- ❑ Arthritis
- ❑ Stomach ulcers
- ❑ Heartburn or acid reflux
- ❑ Fibromyalgia
- ❑ Sleep apnea/ Snoring
- ❑ OTHER:_________________________________

Do you smoke or use chewing tobacco? ❑ Yes ❑ No

If so, how interested are you in stopping? ❑ Not ❑ Very ❑ ?

When cut, do you stop bleeding quickly? ❑ Yes ❑ No

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Bananas
- ❑ Penicillin
- ❑ Clindamycin
- ❑ Local anesthetics ("Novocain")
  Symptoms:_____________________________
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Metals or jewelry
- ❑ Other:_____________________________________

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Bone density or bone pain medicine (Fosamax®, Reclast®, Actonel®, Aredia®, or Zometa®
- ❑ Other:____
  ____

Have you ever been told that you need to take medicine before going to the dentist? ❑ Yes ❑ No
What?________________

Women:

- ❑ May be pregnant
  Expected delivery date: _____________
- ❑ Taking hormones or birth control pills
- ❑ Nursing

Name of your physician:______________________________ **Name of your last dentist:**___________________________________

Do you have any disease, condition, or problem not listed above?____

 Patient Name:__________________________

How often to you have a headache? ❑ Daily ❑ Monthly ❑ More than 2 times a month ❑ Never

Please describe your headaches:____

How often do you have jaw joint noises, pops, or clicks? ❑ Daily ❑ Occasionally ❑ Never

Does your jaw ever lock open or closed? ❑ Yes ❑ No

Have you ever worn a nightguard or bite splint? ❑ Yes ❑ No If so, why?_____________________

Are you having pain today? ❑ Yes ❑ No Where?_____________________________

Is there anything that you would like to change about your smile?________________________

I acknowledge that the medical/dental information that I have given today about myself, or about the individual named on this form for whom I am legally responsible, is correct and complete to the best of my knowledge. I also understand that it is my responsibility to update this medical information whenever a change occurs. I hereby consent to and authorize appropriate diagnostic procedures (including but not limited to x-rays, impressions, photographs, etc.) needed to be performed in order to obtain an adequate diagnosis of the individual named on this form. I hereby give permission to Dr. Huff and his staff to share information concerning health history, diagnosis, and treatment of the individual named on this form to other healthcare professionals and for educational purposes unless and until I notify them otherwise in writing.

Signature of Patient or Legal Guardian:____________________________ **Date:**____________________

Office Use Only

COMMENTS: DATE:__________________

MEDICAL HISTORY UPDATE:

DATE	CHANGE to MEDICAL HISTORY	MEDICATION CHANGES	PATIENT INITIALS	CLINICIAN INITIALS