Valley Dental

FAMILY DENTISTRY, ORTHODONTICS, & ENDODONT1CS

Name_____Home Phone(___)_____Cell Phone(___)_____
Address_____City/State_____Zip Code_____
Work Phone(___)_____ Height_____ Weight_____ Date of Birth___/___/_____M ☐ F ☐
Emergency Contact_____Relationship_____Phone(___)_____
If you are completing this form for another person, what is your name and relationship to that person?_____

For the following questions please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit 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.

Dental Information

Yes No Unsure
☐ ☐ ☐ Do your gums bleed when you brush?
☐ ☐ ☐ Are your teeth sensitive to cold, hot, sweets, or pressure?
☐ ☐ ☐ Have you had any periodontal (gum) treatments?
☐ ☐ ☐ Have you ever had a serious/difficult problem associated with any previous dental treatment? If so, explain_____

Yes No Unsure
☐ ☐ ☐ Have you ever had orthodontic treatment?
☐ ☐ ☐ Do you have headaches, earaches, or neck pain?
☐ ☐ ☐ Do you wear removable dental appliances?

How would you describe your current dental problem?_____
Date of last dental visit?_____Date of last dental x-rays?_____
What was done at that time?_____
How do you feel about the appearance of your teeth?_____

Medical Information

Yes No Unsure
☐ ☐ ☐ Are you in good health?
☐ ☐ ☐ Has there been any change in your general health within the past year?_____

Do you have any of the following diseases or problems? If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.
☐ ☐ ☐ Active Tuberculosis
☐ ☐ ☐ Persistent cough greater than a 3 week duration
☐ ☐ ☐ Cough that produces blood

☐ ☐ ☐ Are you now under the care of a physician? If so, what is/are the condition(s) being treated?_____
Physician(s)_____Phone_____City/State_____
☐ ☐ ☐ Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, explain?_____
☐ ☐ ☐ Are you taking or have you recently taken any medicine(s) including non-prescription medicine? If so, which one(s) are you taking? Prescribed_____
Over the counter, natural or herbal preparations_____
☐ ☐ ☐ Are you taking or have you taken any diet drugs such as Pondimin(fendluramine), Redux (desphenfluramine) or Phen-fen (phentermine)?
☐ ☐ ☐ Do you drink alcoholic beverages? If yes, how much in the last 24 hours?_____ In the past month?_____
If yes,_____# of drinks per day for_____# years.
☐ ☐ ☐ Are you alcohol and/or drug dependent? If so, have you received treatment? Yes ☐ No ☐
☐ ☐ ☐ Do you use drugs or other substances for recreational purposes? If yes, please list_____
Frequency of use (daily, weekly, etc.)_____Number of years of recreational drug use_____
☐ ☐ ☐ Do you use tobacco (smoking, snuff, chew)? If so, how interested are you in stopping? ☐Very ☐Somewhat ☐Not interested
☐ ☐ ☐ Do you wear contact lenses?

Please see next page

Allergies: Are you allergic to or have you had a reaction to: (please fill out both columns)

Yes	No	Unsure		Yes	No	Unsure	
☐	☐	☐	Local anesthetics	☐	☐	☐	Latex
☐	☐	☐	Aspirin	☐	☐	☐	Iodine
☐	☐	☐	Penicillin or other antibiotics	☐	☐	☐	Hay fever/seasonal
☐	☐	☐	Barbiturates, sedatives, or sleeping pills	☐	☐	☐	Animals
☐	☐	☐	Sulfa drugs	☐	☐	☐	Food(specify)
☐	☐	☐	Codeine or other narcotics	☐	☐	☐	Other(specify)

To yes responses please specify type of reaction_____

(Women Only)

☐ ☐ ☐ Are you pregnant?
☐ ☐ ☐ Nursing?
☐ ☐ ☐ Taking birth control pills?

Please *(X)* whichever applies to you: (Please note there are 3 columns')

☐ ☐ ☐ Have you had an orthopedic total joint(hip, knee, elbow, finger) replacement? If so, when was this operation done? _____
☐ ☐ ☐ Have you had any complications or difficulties with your prosthetic joint?
☐ ☐ ☐ Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?
If so, what antibiotic and dose?_____Name of physician or dentist_____Phone_____

Yes	No	Unsure		Yes	No	Unsure	
☐	☐	☐	Abdominal Bleeding	☐	☐	☐	Disease,drug or radiation induced immunosupression
☐	☐	☐	AIDS or HIV infection	☐	☐	☐	Diabetes
☐	☐	☐	Anemia				☐ Type 1
☐	☐	☐	Arthritis				☐ Type 2
☐	☐	☐	Rheumatoid arthritis	☐	☐	☐	Dry mouth
☐	☐	☐	Asthma	☐	☐	☐	Eating disorder
☐	☐	☐	Blood Transfusion				If yes specify _____
			If yes, date _____	☐	☐	☐	Epilepsy
☐	☐	☐	Cancer/chemotherapy/ radiation treatment	☐	☐	☐	Fainting spells or seizures
☐	☐	☐	Cardiovascular disease	☐	☐	☐	Gastrointestinal reflux
			If yes, specify below	☐	☐	☐	Glaucoma
			☐ Angina	☐	☐	☐	Hemophilia
			☐ Arteriosclerosis	☐	☐	☐	Hepatitis, jaundice, liver disease
			☐ Artificial heart valves	☐	☐	☐	Recurrent infections
			☐ Coronary insufficiency				Indicate type infection
			☐ Coronary occlusion				_____
			☐ Damaged heart valves	☐	☐	☐	Kidney problems
			☐ Heart attack	☐	☐	☐	Low blood pressure
			☐ Heart murmur	☐	☐	☐	Mental health disorders
			☐ High blood pressure				If yes specify _____
			☐ Inborn heart defects				_____
			☐ Mitral valve prolapse				_____
			☐ Pacemaker				
			☐ Rheumatic heart disease				
☐	☐	☐	Chest pain upon exertion	☐	☐	☐	Malnutrition
☐	☐	☐	Chronic pain	☐	☐	☐	Migraines
☐	☐	☐	Persistent diarrhea	☐	☐	☐	Night sweats

Yes	No	Unsure	
☐	☐	☐	Neurological disorders
			If yes specify _____
☐	☐	☐	Osteoporosis
☐	☐	☐	Persistent swollen glands in neck
☐	☐	☐	Respiratory problems
			If yes specify
			☐ Emphysema
			☐ Bronchitis, etc.
☐	☐	☐	Severe headaches
☐	☐	☐	Severe or rapid weight loss
☐	☐	☐	Sexually transmitted disease
☐	☐	☐	Sinus trouble
☐	☐	☐	Sleep disorder
☐	☐	☐	Sores or ulcers in the mouth
☐	☐	☐	Stroke
☐	☐	☐	Systemic lupus erythematosus
☐	☐	☐	Thyroid problems
☐	☐	☐	Tuberculosis
☐	☐	☐	Ulcers
☐	☐	☐	Excessive urination
☐	☐	☐	Do you have any disease, condition or problem not listed above that you think I should know about?
			_____
			_____
			_____

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. 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.

*X*_____
Signature of Patient/Legal Guardian Date

For completion by dentist

Comments on patient interview concerning health history _____
_____
Significant findings from questionnaire or oral interview _____
_____
Dental management considerations_____
_____
Signature of Dentist
Health History Update: on a regular basis the patient should be questioned about any medical history changes, date and comments notated.