Your Health History

Name ____ Preferred Name ____ Date ____

Home Phone ____ Cell ____ Work ____

Home Address ____ City ____ State ____ Zip ____

Date of Birth ____ Occupation ____ Employer/School Name ____

Email Address ____ ☐ Male ☐ Female

Emergency Contact Person ____ Relationship ____ Phone ____

Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed Spouse and Family Members ____

Last Dental Visit / Previous Dentist ____ Preferred Method for Reminders ☐ Text ☐ Phone ☐ Email ☐ Mail

Dental History

- Y N ? Do your gums bleed when you brush?
- Y N ? Have you had orthodontic treatment?
- Y N ? Are your teeth sensitive to cold, hot, sweets, pressure?
- Y N ? Do you have headaches, earaches or neck pain?
- Y N ? Have you had any periodontal (gum) treatments?
- Y N ? Do you wear removable/fixed dental appliances?
- Y N ? Have you been told you have gum disease?
- Y N ? Are you aware of loose teeth or broken fillings?
- Y N ? Do you play contact sports?
- Y N ? Are you a mouth breather?
- Y N ? Have you had any problems associated with any previous dental treatment or past dental experiences?
- Y N ? Do you frequently get blisters on lips or mouth?
- Y N ? Do you have a family history of Periodontal Disease?
- Y N ? Do you get a burning sensation on your tongue?
- Y N ? Do you chew on one side of your mouth?
- Y N ? Do you get clicking or popping in your jaw?
- Y N ? Do you bite your nails or foreign objects?
- Y N ? Do you get jaw pain or tiredness?
- Y N ? Does food collect between your teeth?
- Y N ? Do you have pain when brushing?
- Y N ? Are your gums swollen or tender?
- Y N ? Do you or have you been told that you grind your teeth?

What are your current dental concerns? ____

Oral habits

- ☐ Tongue/lip piercing ☐ Ice chewing
- ☐ Musical instrument with mouthpiece
- ☐ Using mouth as a tool

What fluoride products do you use/consume?

- ☐ Toothpaste ☐ Rinse/mouthwash
- ☐ Other ____

How do you feel about the appearance of your teeth? ____

Do you have any problems with bad breath? ____

How often do you floss? ____ Brush? ____

How often do you have dental check ups? ____

How did you hear about us? Who can we thank for telling you about us? ____

Your Health History

Physician's Name		Phone	
Address		City	
State		Zip	

Y N ? Are you in good health?

Y N ? Have there been any changes in your health within the past year?

Y N ? Are you under the care of a physician? If so, what are the conditions being treated?
Date of last exam: ____________

Y N ? Have you ever had any serious illness, operation, or been hospitalized in the past five years? If so, what was the illness or problem? ____________

Y N ? Do you consume snacks/beverages containing sugar between meals?
How many times per day? ____________

Do you drink alcohol?
☐ No ☐ Yes ______ Drinks per week

Do you smoke cigarettes?
☐ No ☐ Yes ______ Cigarettes per day

Do you smoke anything else? ☐ No ☐ Yes
Substance ______ ______ per week

Do you use smokeless Tobacco?
☐ No ☐ Yes ______ times per week

Are you taking any prescription or over-the-counter medications?

Are you allergic to any of the following?

- Y N ? Local Anesthetics
- Y N ? Penicillin, other antibiotics
- Y N ? Barbiturates, sedatives, sleeping pills
- Y N ? Sulfa Drugs
- Y N ? Codeine or other narcotics
- Y N ? Latex
- Y N ? Iodine
- Y N ? Hay fever / Seasonal
- Y N ? Metal
- Y N ? Other ____________

Please list any drugs or medicines that you cannot or prefer to not take because of allergies or side-effects (especially antibiotics for infections, analgesics for pain, and anesthetics) ____________

Acknowledgement of Receipt of Notice of Privacy Practices (you may refuse to sign)

☐ I was offered this office's Notice of Privacy Practices

☐ I received a copy of this office's Notice of Privacy Practices

Signature ____________ Date ____________

Office use only

When attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ A Communication barrier prohibited obtaining the acknowledgement

☐ An Emergency situation prevented us from obtaining acknowledgement

ISKOL FISK DDS

Your Health History

Please mark a response to indicate if you have or had any of the following diseases or problems:

Y N ? Abnormal Bleeding

Y N ? HIV or AIDS

Y N ? Anemia

Y N ? Herpes

Y N ? Arthritis

Y N ? Rheumatoid Arthritis

Y N ? Asthma

Y N ? Blood Transfusion, Date: ____________

Y N ? Cancer/Chemotherapy/Radiation

Y N ? Cardiovascular diseases? (check all that apply)

- ☐ Angina Pectoris
- ☐ Pacemaker
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Bypass Surgery
- ☐ Artificial Valves
- ☐ Mitral Valve Prolapse
- ☐ Heart Attack

Y N ? Recurrent Infection
If yes, what type of infection? ____________

Y N ? Respiratory problems -- If yes, please specify

- ☐ Emphysema
- ☐ Other ____________
- ☐ Bronchitis, etc.

Y N ? Stroke
If yes, date: ____________

Y N ? Eating disorder
If yes, specify: ____________

Y N ? G.E. Reflux, persistent heartburn, or Gastrointestinal Disease

Y N ? Chest Pain/Shortness of breath upon exertion

Y N ? Disease, drug or radiation-induced immunosuppression

Y N ? Are you pregnant?

Y N ? Are you planning to be pregnant?

Y N ? Have you ever been told you needed to pre-medicate for dental treatment?

Y N ? Chronic Pain

Y N ? Hemophilia

Y N ? Hepatitis, Jaundice, or Liver Disease

Y N ? High/Low Blood Pressure

Y N ? Diabetes

Y N ? Epilepsy

Y N ? Fainting spells or seizures

Y N ? Dry mouth

Y N ? Joint replacement

Y N ? Mental health disorder

Y N ? Night sweats/Menopausal

Y N ? Neurological disorders

Y N ? Osteoporosis

Y N ? Persistent swollen glands

Y N ? Severe headaches/migraines

Y N ? Severe or rapid weight loss

Y N ? Sexually transmitted disease

Y N ? Sinus trouble

Y N ? Sores or ulcers in the mouth

Y N ? Systemic Lupus Erythematosus

Y N ? Tuberculosis

Y N ? Thyroid problems

Y N ? Ulcers

Y N ? Excessive urination/thirst

Y N ? Do you have any disease not listed above that you think we should know about?
If yes, please explain: ____________

____

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 because of errors or omissions that I may have made in the completion of this form.

Signature ____________ Date ____________

Your Health Updates

I have reviewed the attached medical/dental history and have noted any changes. (Fill out once each visit)

Date		Comments/Changes	
Patient/Guardian Signature		Signature of Dentist/Hygienist	

Date		Comments/Changes	
Patient/Guardian Signature		Signature of Dentist/Hygienist	

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