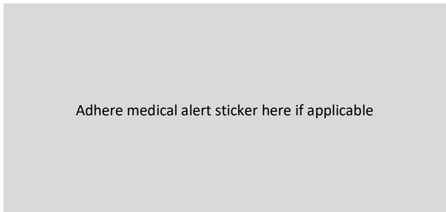

Adhere medical alert sticker here if applicable

HEALTH HISTORY FORM

Date: ____ / ____ / ____

Patient's Name: ______________________ **Preferred Name:** ______________
LAST FIRST MIDDLE INITIAL

Preferred Pronoun (circle): He/Him She/Her They/Them **Date of Birth:** __________ **Age:** ______

Address: ____________________________________
STREET CITY STATE ZIP

Phone: ( ) ____________ **Type (circle):** Home Cell Work **Email:** ______________

Emergency Contact: ______________ **Relationship:** __________ **Phone:** __________

	YES	NO	DK
Have you had any of the following diseases or problems?........	☐	☐	☐

1. Active Tuberculosis, 2. Persistent cough greater than 3 week duration, 3. Cough that produces blood, 4. Exposed to someone with tuberculosis?

If you answered yes to any of the above 4 questions, please stop and return this form to the receptionist.

DENTAL INFORMATION- *Please mark your responses to the following questions*

	YES	NO	DK
Do your gums bleed when you brush or floss?..	☐	☐	☐
Are your teeth sensitive to cold, hot or sweets?.	☐	☐	☐
Does food or floss catch between your teeth?...	☐	☐	☐
Is your mouth dry?........	☐	☐	☐
Have you had periodontal/gum treatments?.....	☐	☐	☐
Have you had orthodontic (braces) treatment?..	☐	☐	☐
Have you had any problems associated with previous dental treatment?........	☐	☐	☐
Is your home water supply fluoridated?............	☐	☐	☐
Do you drink bottled or filtered water?.............	☐	☐	☐

If so, how often? (circle one) DAILY WEEKLY OCCASIONALLY

What is the reason for your dental visit today? ______________

How do you feel about your smile? ______________

	YES	NO	DK
Are you currently experiencing dental pain or discomfort?..	☐	☐	☐
Do you have earaches or neck pains?........	☐	☐	☐
Do you have any popping or discomfort in the jaw?............	☐	☐	☐
Do you brux or grind your teeth?........	☐	☐	☐
Do you have sores or ulcers in your mouth?........	☐	☐	☐
Do you wear dentures or partials?........	☐	☐	☐
Do you participate in recreational activities?........	☐	☐	☐
Have you ever had a serious injury to your head or mouth?.	☐	☐	☐

DENTAL APPOINTMENT HISTORY

Date of your last dental exam: ____ / ____ / ____

What was done? ______________

Date of last dental x-rays: ____ / ____ / ____

Dentist name and contact information: ______________

MEDICAL INFORMATION- *Please mark your response to the following questions*

	YES	NO	DK
Are you now in the care of a physician?.............	☐	☐	☐

Physician's name: ______________

Phone number: ______________

Address: ______________

City/State/Zip: ______________

	YES	NO	DK
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 your last physical exam? ____ / ____ / ____

	YES	NO	DK
Have you had a serious illness, operation or been hospitalized in the last 5 years?........	☐	☐	☐

If yes, what was the illness or problem? ______________

	YES	NO	DK
Are you taking any prescription or over the counter medications?........	☐	☐	☐

If yes, please list them all, including vitamins, natural supplements:

____

Please complete both sides of this form.

	YES	NO	DK
Do you wear contact lenses?..	☐	☐	☐

JOINT REPLACEMENT:

	YES	NO	DK
Have you had and orthopedic joint replacement (hip, knee, elbow, or finger) replacement?..........................	☐	☐	☐
Date of replacement: ______/______/______			
If yes, have you had any complications?............	☐	☐	☐
Are you taking or scheduled to start taking any medications for osteoporosis?...............................	☐	☐	☐

	YES	NO	DK
Have you ever been treated with intravenous bisphosphonates (Reclast, Aredia, Boniva) for bone pain, hypercalcemia, Paget's disease, multiple myeloma, or metastatic cancer?....................................	☐	☐	☐
Date treatment began: ______/______/______			
Do you use recreational drugs?......................................	☐	☐	☐
What is your weekly alcohol consumption? _____ drinks/ week			
Do you smoke (cigarettes, cigars, marijuana, vape, hookah) or use smokeless tobacco?...............................	☐	☐	☐
If yes, are you interested in quitting?....................	☐	☐	☐

WOMEN ONLY:	YES	NO	NA
Are you pregnant?..	☐	☐	☐
If yes, how many weeks? __________			
Are you taking birth control or hormonal replacement?.	☐	☐	☐
Are you nursing?..	☐	☐	☐

ALLERGIES: Are you allergic to or have you had a reaction to any of the following? ***If yes, please specify the type of reaction you had.***

	YES	NO	DK
Local anesthetics..	☐	☐	☐
Aspirin..	☐	☐	☐
Penicillin or other antibiotics..	☐	☐	☐
Codeine or other narcotics..	☐	☐	☐
Other medication(s)- please specify...............................	☐	☐	☐
Metals..	☐	☐	☐
Latex..	☐	☐	☐
Seasonal allergies..	☐	☐	☐
Food...	☐	☐	☐
Any other allergy- please specify..	☐	☐	☐

The following conditions require antibiotic prophylaxis prior to dental treatment	YES	NO	DK
Artificial (prosthetic) heart valve..	☐	☐	☐
Previous history of infective endocarditis..................................	☐	☐	☐
Damaged heart valves in a transplanted heart..........................	☐	☐	☐
CONGENITAL HEART DISEASE (CHD)			
Unrepaired, cyanotic CHD..	☐	☐	☐
Repaired completely in the last 6 months..........................	☐	☐	☐
Repaired CHD with residual effect......................................	☐	☐	☐

	YES	NO	DK
Cardiovascular disease	☐	☐	☐
Heart Attack..............	☐	☐	☐
If yes, date: __________			
Angina/ Chest Pain.....	☐	☐	☐
Congestive heart failure...........................	☐	☐	☐
Heart murmur.............	☐	☐	☐
Low blood pressure.....	☐	☐	☐
High blood pressure....	☐	☐	☐
Congenital heart defects..........................	☐	☐	☐
Pacemaker.................	☐	☐	☐
If yes, year placed: __________			
Damaged heart valves	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Rheumatic fever or heart disease.............	☐	☐	☐
Type I Diabetes.........	☐	☐	☐
Type II Diabetes.........	☐	☐	☐
Cancer........................	☐	☐	☐
Chemotherapy/ Radiation....................	☐	☐	☐

	YES	NO	DK
Stroke..............................	☐	☐	☐
If yes, date: __________			
Neurological disorder....	☐	☐	☐
Epilepsy/seizures...........	☐	☐	☐
Fainting spells................	☐	☐	☐
Asthma............................	☐	☐	☐
Emphysema/COPD.........	☐	☐	☐
Chronic Bronchitis..........	☐	☐	☐
Tuberculosis....................	☐	☐	☐
Sinus trouble.................	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
GERD/Reflux/Heartburn	☐	☐	☐
Ulcers..............................	☐	☐	☐
Thyroid Problems...........	☐	☐	☐
Autoimmune disease.....	☐	☐	☐
Arthritis...........................	☐	☐	☐
Chronic pain...................	☐	☐	☐
Systemic lupus erythematosus...............	☐	☐	☐

	YES	NO	DK
Osteoporosis.............	☐	☐	☐
Glaucoma...................	☐	☐	☐
Night sweats..............	☐	☐	☐
Kidney problems........	☐	☐	☐
Excessive urination....	☐	☐	☐
Sleep disorder...........	☐	☐	☐
Mental health disorder	☐	☐	☐
If yes: specify: __________			
Eating disorder..........	☐	☐	☐
Cold sores..................	☐	☐	☐
Severe migraines......	☐	☐	☐
Hepatitis/liver disease	☐	☐	☐
Abnormal bleeding....	☐	☐	☐
Blood disorders..........	☐	☐	☐
Blood transfusion......	☐	☐	☐
If yes, date: __________			
HIV or AIDS................	☐	☐	☐
Sexually transmitted disease.......................	☐	☐	☐

	YES	NO	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?..	☐	☐	☐
If yes, please explain: ______________________________			
Do you have any disease, condition, or problem not listed above?..	☐	☐	☐
If yes, please explain: ______________________________			

NOTE: Both dental team 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 RCBC 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 RCBC or any other member of the 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: ______________

Student Signature: ______________________ Date: ______________

Instructor Signature: ______________________ Date: ______________