TWAIN HARTE
FAMILY DENTAL CARE
A Professional Dental Corporation

Health History Questionnaire (Confidential)

Patient Name_____ **Date**_____

Physicians Name_____**Phone #**_____

1. Have you (has the patient) ever had any health problem in the past five (5) years?…… Yes No
2. Have you (has the patient) seen a doctor (MD or DO) in the past five (5) years?……..…… Yes No
   If yes, for what reason?_____
   _____
3. Have you (has the patient) been in the hospital in the past (5) five years?……. Yes No
   If yes, for what reason?_____
   _____
4. Have you (has the patient) had a serious illness in the past five (5) years?……..Yes No
   If yes, what illness?_____
   _____
5. Is there any activity your doctor says you (the patient) cannot do?……. Yes No
   If yes, what?_____
   _____
6. Have you (has the patient) ever had a bleeding problem?…… Yes No

Please circle the appropriate response for the following questions.

Heart/Blood Vessels
Rheumatic fever……. Yes No
Rheumatic heart disease……Yes No
Heart valve damage…… Yes No
Heart murmur…… Yes No
Congenital heart defect…….. Yes No
Artificial heart valve……..…. Yes No
High blood pressure……..…. Yes No
Heart attack……..…. Yes No
TIA / Stroke…… Yes No
Heart surgery…… Yes No
Angioplasty……..…. Yes No
Vascular surgery……..…. Yes No
Pacemaker……..…. Yes No
Coronary heart disease…..…. Yes No
Congestive heart failure……. Yes No
Angina pectoris……..…. Yes No
Chest pain……..…. Yes No
Irregular heart beat…… Yes No
Rapid heart beat……. Yes No
Other heart / vessel disorder.. Yes No

Blood
Blood clots or thrombosis..… Yes No
Anemia……..…. Yes No
Sickle cell disease / trait……Yes No
Hemophilia……..…Yes No
Bleeding disorder……..…. Yes No
Bruise easily for no
apparent reason……..… Yes No
Other blood disorder……..… Yes No

Nervous System
Epilepsy……..Yes No
Seizure disorder……. Yes No
Multiple sclerosis……..……..Yes No
Trigeminal neuralgia……..…..Yes No
Psychiatric treatment…….. Yes No
Psychological counseling….. Yes No
Persistent numbness/tingling...Yes No
Other nervous system disorder. Yes No

Head & Neck
Glaucoma…….……..…..Yes No
Chronic sinusitis……..… Yes No
Injury to head,
neck, face, teeth……Yes No
Headaches……..…..Yes No
Unexplained visual change….Yes No
Frequent or severe
nosebleeds……..…….. Yes No
Persistent sore throat
or hoarseness……..……...Yes No
Difficulty swallowing…..…...Yes No
Other head / neck disorder.....Yes No

Endocrine
Diabetes Type I or II…….. Yes No
Low thyroid…….…...Yes No
Other thyroid condition…..…..Yes No
Cushing's syndrome……..Yes No
Parathyroid condition..…..….Yes No
Pituitary condition……..…..Yes No
Other endocrine condition…..Yes No

Musculoskeletal
Sjogren's syndrome…….....Yes No
Arthritis……..……...Yes No
Artificial joint……..……..Yes No
Fibromyalgia/rheumatism…...Yes No
Chronic back pain……..Yes No
Other bone/muscle disorder... Yes No

Respiratory
Tuberculosis…….. Yes No
Asthma…….. Yes No
Chronic bronchitis……..Yes No
Emphysema……..……..Yes No
Persistent cough……..…….. Yes No
Cough up bloody sputum….. Yes No
Shortness of breath……..….. Yes No
Other respiratory……..…….. Yes No

Urinary Tract
Kidney disease……..…….. Yes No
Renal dialysis……..…….. Yes No
Venereal disease……..…….. Yes No
Sexually transmitted disease...Yes No
Other urinary disorder…….. Yes No

Digestive System
Hepatitis……..…….. Yes No
Liver disease…….. Yes No
Cirrhosis of the liver…….. Yes No
Ulcers……..…….. Yes No
Jaundice……..Yes No
Frequent heartburn…..…….Yes No
GERD……..…….Yes No
Acid reflux……..Yes No
Frequent nausea/vomiting…...Yes No
Other digestive disorder……. Yes No

Cancer History

Leukemia……..……..Yes No
Benign tumors/growths……..Yes No
Cancer……..…….. Yes No

If yes, what type: _____
If yes, treatment:
[ ] Surgery
[ ] Radiation
[ ] Chemotherapy
[ ] Hormone therapy
Other cancer……..…….. Yes No

Allergy History

Are you allergic to or have you ever had a bad reaction to the following:
Dental anesthetics…...…….. Yes No
Penicillin……..…….. Yes No
Sulfa drugs……..…….. Yes No
Other antibiotics……..……..Yes No
Aspirin…….…….. Yes No
Latex products……..……..Yes No
Metals / jewelry……...……..Yes No
Other allergy……..…..…….. Yes No

Family History

Has anyone in your family (grandparents, parents, siblings, children) ever had:
Diabetes? ……..……..Yes No
Heart disease? ……..…….. Yes No
Depression/anxiety? ……..Yes No
Tuberculosis? ……..…..Yes No
Bleeding disorder? ……..... Yes No

Anything else that runs in the family? …..……..Yes No
If yes, describe_____

Miscellaneous

Lupus erythematosus…….....Yes No
Organ transplant……..…….Yes No
If yes, which organ? ……..…..Yes No
Suppressed immune system.... Yes No
Persistent fever……..……Yes No
Taken steroids……..…..…..Yes No
Taken prednisone / cortisone...Yes No
Taken prescription diet pills....Yes No
If yes, which?
[ ] Pondimin
[ ] Redux
[ ] Phen-phen
[ ] Other
Have you, or are you currently taking Fosamax or similar bisphosphonate medication..…Yes No
Use/used tobacco products..…Yes No
Smoke……..…..…..Yes No

How many packs per day?_____
How long? _____

Chew tobacco……..…....Yes No

Drink alcoholic beverages…...Yes No
If yes, how much?_____

Used recreational drugs (cocaine, crack, heroine, speed etc)…….....Yes No
If yes, what type?_____
Are you a recovering alcoholic or addict? ...…….. Yes No

Other

Down syndrome…….. Yes No
Developmental delay……. Yes No
Mental retardation…… Yes No
Cerebral palsy…… Yes No
Autism……Yes No
ADHD……Yes No
Combative / aggressive…..... Yes No
Self-abusive……Yes No
Surgical:
VP shunt or revisions……. Yes No
Vagal nerve stimulator……Yes No
Blood transfusion……Yes No

When? _____

Women Only

Are you pregnant? ……..…..Yes No
Is there a chance you could be pregnant? ……... Yes No
Are you nursing (breast-feeding)? ……..…….. Yes No
Are you taking birth control pills?.....Yes No

Circle the following drugs that you are (the patient is) taking or have taken

Heart pills	Oral contraceptive	Antibiotics
Nitroglycerin	Steroids/Cortisone	Antihistamines
Digitals	Hormones	Cyclosporine A
Aspirin	Insulin	Tranquilizers
Blood thinners	Diabetic drugs	Sleeping pills
Blood pressure	Thyroid	Antidepressants

List all medications and doses that you are (the patient is) now taking:

_____

_____

_____

_____

_____

I UNDERSTAND THAT THE INFORMATION THAT I HAVE GIVEN TODAY IS CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT THIS INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE, AND IT IS MY RESPONSIBILITY TO INFORM THE OFFICE OF ANY CHANGES IN MY MEDICAL OR DENTAL STATUS.
I AUTHORIZE THE DENTAL STAFF TO PERFORM ANY NECESSARY DENTAL SERVICES THAT I MAY NEED DURING DIAGNOSIS AND TREATMENT WITH MY INFORMED CONSENT.

_____ _____
Name of person filling out form Relationship to patient

If you are not the patient, are you able to give legal consent for the patient? Yes No If "No," who does?

_____
Name of person able to give consent

_____ _____
Signature of parent / guardian / person filling our form Date

_____ _____
Signature of dentist (I verbally reviewed the medical information above with the patient) Date