BAY AREA SPECIALISTS IN CONTEMPORARY PROSTHODONTICS

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Confidential Health History Form

Today's Date _____

Patient Name: First _____ MI _____ Last _____ **Date of Birth** _____

I. Chief Complaint (What is your primary reason/concern for seeking dental treatment?): _____

_____

II. Circle appropriate answer *(Leave blank if you do not understand the question)*

1. **Yes | No** **Is your general health good?**
   If NO, explain _____
2. **Yes | No** **Has there been a change in your health within the last year?**
   If YES, explain _____
3. **Yes | No** **Have you gone to the hospital or emergency room or had a serious illness in the last three years?**
   If YES, explain _____
4. **Yes | No** **Are you being treated by a physician now?**
   If YES, explain _____
   Date of last medical exam _____ **Reason for exam** _____
5. **Yes | No** **Have you had problems with prior dental treatment?**
   If YES, explain _____
   Date of last dental exam _____ **Name of last treating dentist** _____
6. **Yes | No** **Are you in pain now?**
   If YES, explain _____

III. Have you experienced any of the following? (*Please circle Yes or No for each)*

Yes	No	Chest pain (angina)	Yes	No	Blood in stools	Yes	No	Frequent vomiting
Yes	No	Fainting spells	Yes	No	Diarrhea or constipation	Yes	No	Jaundice
Yes	No	Recent significant weight loss	Yes	No	Frequent urination	Yes	No	Dry mouth
Yes	No	Fever	Yes	No	Difficulty urinating	Yes	No	Excessive thirst
Yes	No	Night sweats	Yes	No	Ringing in ears	Yes	No	Difficulty swallowing
Yes	No	Persistent cough	Yes	No	Headaches	Yes	No	Swollen ankles
Yes	No	Coughing up blood	Yes	No	Dizziness	Yes	No	Joint pain or stiffness
Yes	No	Bleeding problems	Yes	No	Blurred vision	Yes	No	Shortness of breath
Yes	No	Blood in urine	Yes	No	Bruise easily	Yes	No	Sinus problems

IV. Have you had or do you have any of the following? *(Please circle Yes or No for each)*

Yes	No	Heart disease	Yes	No	Cosmetic surgery	Yes	No	Eating disorder

Yes I No	Family history of heart disease	Yes I No	Surgeries	Yes I No	Osteoporosis
Yes I No	Heart attack	Yes I No	Hospitalization	Yes I No	Thyroid disease
Yes I No	Artificial joint	Yes I No	Diabetes	Yes I No	Asthma
Yes I No	Stomach problems or ulcers	Yes I No	Family history of diabetes	Yes I No	Hepatitis
Yes I No	Heart defects	Yes I No	Tumors or cancer	Yes I No	Sexual transmitted disease
Yes I No	Heart murmurs	Yes I No	Chemotherapy	Yes I No	Herpes
Yes I No	Rheumatic fever	Yes I No	Radiation	Yes I No	Canker or cold sores
Yes I No	Skin disease	Yes I No	Arthritis, rheumatism	Yes I No	Anemia
Yes I No	Hardening of arteries	Yes I No	Emphysema or lung disease	Yes I No	Liver disease
Yes I No	High blood pressure	Yes I No	Kidney or bladder disease	Yes I No	Eye disease
Yes I No	Seizures	Yes I No	Stroke	Yes I No	Transplants
Yes I No	Tuberculosis	Yes I No	Pacemaker	Yes I No	Family history of cancer

This following information will *not* be released unless specifically authorized by patient.

Yes I No AIDS/HIV Yes I No Anxiety Yes I No Depression Yes I No Treatment for emotional condition

V. Are you *allergic* to or have you had a reaction to any of the following? (*Please circle Yes or No for each)*

Yes I No	Latex	Yes I No	Valium	Yes I No	Tetracycline
Yes I No	Darvon	Yes I No	Demerol	Yes I No	Vicodin
Yes I No	Codeine	Yes I No	Penicillin	Yes I No	Percodan
Yes I No	Aspirin	Yes I No	Erythromycin	Yes I No	Nitrous oxide
Yes I No	Local anesthetic (Novocain or Xylocaine)	Yes I No	Epinephrine	Yes I No	Metals
				Yes I No	Any Foods

Other allergies or allergic reactions NOT mentioned above_____

VI. Are you taking or have you taken any of the following in the last three months? *(Please circle Yes or No for each)*

Yes I No	Recreational drugs	Yes I No	Cigarettes	Yes I No	Antibiotics
Yes I No	Over-the-counter medications	Yes I No	Tobacco in any other forms	Yes I No	Supplements
Yes I No	Weight loss medications	Yes I No	Bisphosphonates (Fosamax)	Yes I No	Aspirin
Yes I No	Cortico - Steroids	Yes I No	Alcohol		

Please list ***all medications*** you are currently taking _____

_____

VII. Women only *(Please circle Yes or No for each)*

Yes I No **Are you or could you be pregnant? If YES, what month?** _____

Yes I No **Are you nursing?**

Yes I No **Are you taking birth control pills? If YES, which one?** _____

VIII. All patients *(Please circle Yes or No for each)*

Yes I No **Do you have or have you had any other diseases or medical problems NOT listed on this form?**
If YES, explain _____

_____

Yes I No **Have you ever been pre-medicated for dental treatment?**
If YES, why _____

Yes I No **Have you ever taken Fen-Phen** (anti-obesity medication)**?**
If YES, when _____

Yes I No **Is there any issue or condition that you would like to discuss with the dentist in private?** _____

IX. Dental-Oral History (please check an answer(s) for each subheading below)

Reason for past dental care:

- ❑ Regular dental visits
- ❑ Mostly emergency visits
- ❑ Other_____

Oral hygiene practices:

- ❑ Brush teeth once daily
- ❑ Brush teeth more than once daily
- ❑ Do not brush teeth daily
- ❑ Floss daily
- ❑ Floss occasionally
- ❑ Never floss
- ❑ Use Waterpik
- ❑ Use mouth wash
- ❑ Use Fluoride rinse

Missing teeth:

- ❑ Yes
- ❑ No
- ❑ Some
- ❑ All

Prostheses:

- ❑ Full upper denture
- ❑ Full lower denture
- ❑ Partial upper denture
- ❑ Partial lower denture

Oral function:

- ❑ Difficulty chewing food
- ❑ Pain / limited jaw opening / closing
- ❑ Jaw locks open or closed
- ❑ Loss / diminished taste or smell

Habits:

- ❑ Biting / sucking lip or cheek
- ❑ Tongue thrusting / finger sucking / nail biting
- ❑ Clenching or grinding teeth

Types of past dental therapy:

- ❑ No history of caries
- ❑ Extraction(s)
- ❑ Caries/restoration during last year
- ❑ Caries/restoration more than one year ago
- ❑ Tooth bleaching
- ❑ Other cosmetic dentistry
- ❑ Orthodontics
- ❑ Root canal therapy
- ❑ Dentures
- ❑ Crowns / bridges
- ❑ Implants
- ❑ Sealants
- ❑ Periodontal therapy
- ❑ Other _____

Chronic oral / facial pain: (past or current)

- ❑ Yes
- ❑ No
- ❑ Jaw / Face / TMJ pain
- ❑ Burning tongue / mouth

Oral Lesions / Ulcerations:

- ❑ Yes
- ❑ No
- ❑ Mouth
- ❑ Lips

Other Important Information (not mentioned above)_____

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.
By signing below, I authorize the dentist to contact my physician.

Patient's Signature_____ Date _____

Physician's Name _____ Phone Number _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____ _____ _____

Signature of **Patient** (Parent or Guardian) Date Signature of **Dentist** Date