

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Preferred Method of Communication: Phone: \_\_\_\_\_ Mail: \_\_\_\_\_ Email: \_\_\_\_\_ Text: \_\_\_\_\_

Advanced Directive/Living Will: Yes \_\_\_\_\_ No \_\_\_\_\_

Occupation: Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Former Dental Provider: \_\_\_\_\_ City/State: \_\_\_\_\_

Date of last dental visit: \_\_\_\_\_ Date of last dental x-ray(s): \_\_\_\_\_

**Habits:** Please circle all that apply.

Smoking:	Never	Former	Presently	# of packs/day
Alcohol:	None	Rarely	Occasionally	Socially
Drug Use:	None	Former	Presently	Type:
Caffeine:	None	1-2 cups/day	3-4 cups/day	More than 5 cups/day
Exercise:	None	Intermittently	Regularly	

**Current Medication List:** Please include any over-the-counter drugs, herbal supplements, vitamins, and birth control.

No Current Medications: \_\_\_\_\_

Medication	Dosage (mg)	Frequency	Prescribing Physician

**Allergies:** Please include food, drug, and environmental allergies.

No Known Allergies: \_\_\_\_\_

Allergy	Interaction	Allergy	Interaction

Previous Surgery History: Please list below.

No Past Surgical History: \_\_\_\_\_

Surgery	Year	Complications?

Relevant Family Medical History: Please check all that apply.

No Relevant Family History: \_\_\_\_\_

	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts/Uncles
Cancer									
Diabetes									
High Blood Pressure									
Heart Attack									
Heart Disease									
Blood Clots/DVT									
Stroke									
Mental Illness									
Drug/Alcohol Addiction									
Other Diseases Not Mentioned									
<b>Living/Deceased</b>									

Medical Problems: Please check all that apply.

No Medical Problems: \_\_\_\_\_

Abdominal discomfort	Headaches	Sinus trouble
Acid reflux	Heart attack	Skin rash/disorders
ADD	Heart disease	Special diet
ADHD	Heart murmur	Stroke
AIDS/HIV	Hepatitis: specify A, B, C	Swollen feet/ankles
Alcohol/drug abuse	High blood pressure	Swollen neck glands
Anemia	High cholesterol	Thyroid problems
Anxiety	Kidney disease	Tonsillitis
Asthma	Kidney stones	Tuberculosis
Arthritis, Rheumatism	Liver disease	Tumor or growths
Artificial heart valves	Low blood pressure	Ulcers

	Artificial joints		Jaundice	<b>DENTAL HISTORY</b>	
	Autism		Joint replacement		Bad breath
	Back problems		Migraines		Bleeding gums
	Bleeding abnormally with extractions or surgery		Light-headedness		Blisters on lips/mouth
	Blood disease		Lung disease		Burning sensation on tongue
	Bronchitis		Mitral valve prolapsed		Chew on side of mouth
	Cancer		Muscular Dystrophy		Cigarette, or other, smoking
	Chemical dependency		Nervous problems		Clicking or popping jaw
	Circulatory problems		Nausea		Dry mouth
	Congenital heart lesions		Osteoporosis		Fingernail biting
	Cortisone treatments		Pacemaker		Food collection in teeth
	Cough, persistent or bloody		Psychiatric care		Grinding teeth
	Cortisone treatments		Palpitations		Loose teeth/broken fillings
	Colitis		Pneumonia		Mouth pain/brushing
	Diabetes		Radiation treatment		Pain around ear
	Depression		Respiratory disease		Periodontal treatment
	Emphysema		Recent surgery		Sensitive to hot/cold/sweets
	Epilepsy		Rheumatic fever		Sensitive when biting
	Fainting or dizziness		Scarlet fever		Sores/growths in mouth
	Glaucoma		Shortness of breath		Bubble/pimple on gum

**Health Maintenance Screenings:** Please circle all that apply.

Colonoscopy	Yes No	Date:	Results:	Normal	Abnormal
FIT/Stool Test	Yes No	Date:	Results:	Normal	Abnormal
Mammogram	Yes No	Date:	Results:	Normal	Abnormal
PAP Smear	Yes No	Date:	Results:	Normal	Abnormal

**Immunization History:** Have you had:

Hepatitis B Series	Yes No	Date:	# of Doses if Known:	
TDaP/Tetanus	Yes No	Date:		
Pneumovax 23	Yes No	Date:		
Prevnar (Pneumo 13)	Yes No	Date:		
Flu	Yes No	Date:		

**Women:**

Are you pregnant? Yes \_\_\_\_\_ Due date: \_\_\_\_\_

No \_\_\_\_\_ Taking birth control pills \_\_\_\_\_

Are you breast feeding? Yes \_\_\_\_\_ No \_\_\_\_\_

**Lifestyle:**

Support Person #1: \_\_\_\_\_

Support Person #2: \_\_\_\_\_

Military Experience:      Yes \_\_\_\_\_      No \_\_\_\_\_

Education: (Highest grade completed) \_\_\_\_\_

Hobbies/Activities: \_\_\_\_\_

Religion: \_\_\_\_\_

Have you recently traveled outside the area?      Yes \_\_\_\_\_      No \_\_\_\_\_

If Yes, where: \_\_\_\_\_

**Residence Information:**

Housing Status: \_\_\_\_\_

Smoke Detectors:      Yes \_\_\_\_\_      No \_\_\_\_\_

Firearms in the Home:      Yes \_\_\_\_\_      No \_\_\_\_\_

Have you ever been a victim of abuse or domestic violence?      Yes \_\_\_\_\_      No \_\_\_\_\_

Do you feel safe at home?      Yes \_\_\_\_\_      No \_\_\_\_\_

Do you live alone?      Yes \_\_\_\_\_      No \_\_\_\_\_

Please complete this health history and mail (in the postage paid envelope provided), drop off to one of our locations, or fax to us prior to your appointment.

If you cannot return this form prior to your appointment, you must arrive 15 minutes early, so you can complete the form.

**Thank you for your cooperation and we look forward to having you as a patient!**