HEALTH HISTORY

*This form must be updated two years from the initial date, and it must be written in **black** or **blue** ink.*

Name _____ Home phone _____
LAST FIRST MIDDLE

Work phone _____ Cell _____ Other phone _____

Address _____ City _____ State _____ ZIP _____

Occupation _____ Height _____ Weight _____ Date of birth ___/___/___ Sex ○M ○F

Emergency contact _____ Relationship _____ Phone _____

For the following questions, check whichever applies. Your answers are for our records only and are kept confidential in accordance with applicable laws. **During your appointments, you'll be asked questions about your responses to the questionnaire, and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This clinic doesn't use this information to discriminate.**

Dental information

Yes	No	Don't know	
○	○	○	Do your gums bleed when you brush?
○	○	○	Are your teeth sensitive to hot, cold, sweets or pressure?
○	○	○	Have you had any periodontal (gum) treatment or dental implants?
○	○	○	Have you ever had orthodontic (braces) treatment?
○	○	○	Do you wear removable dental appliances?
○	○	○	Have you ever had a dental implant placed? If yes, describe place in mouth and date placed. _____

_____

○ ○ ○ Have you had a serious/difficult problem associated with any previous dental treatment? If so, explain.

_____

How would you describe your current oral health? _____

Date of your last dental exam _____ Date of last dental cleaning _____ Date of last dental X-rays _____

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

Medical information

Yes	No	Don't know	
○	○	○	Are you in good health?
○	○	○	Has there been any change in your health in the past year?
○	○	○	Do you have active tuberculosis?
○	○	○	Do you have a persistent cough longer than three weeks in duration?
○	○	○	Do you have a cough that produces blood?
○	○	○	Are you now under the care of a physician? If so, what is/are the condition(s) being treated?

_____

Physician(s) _____
Name Phone City/state

_____
Name Phone City/state

○ ○ ○ Have you had any serious illness, operation or been hospitalized in the past five years? If so, what was the reason?

_____

○ ○ ○ Are you taking any medications? If so, what medicine(s) are you taking?

Prescribed _____

Over the counter _____

Natural or herbal preparations _____

Yes No Don't know

- Are you taking or have you taken any diet drugs such as Pondimin, Redux or phen-fen?
- Are you alcohol and/or drug dependent? If so, have you received treatment? (Check one.) □ Yes □ No
- Do you use drugs or other substances for recreational purposes? If yes, please list _____
- Do you use tobacco (smoking, snuff, chew)? If so, are you interested in stopping? □ Yes □ No

Allergies: Are you allergic to or have you had a reaction to: (Complete both columns.)

Yes	No	Don't know		Yes	No	Don't know	
			Local anesthetics				Latex
			Penicillin or other antibiotics				Barbiturates, sedatives, sleeping pills
			Sulfa drugs				Hay fever/seasonal
			Codeine or other narcotics				Other (specify) _____

To yes responses, specify type of reaction _____

Check each of the conditions below appropriately.

Yes No Don't know

- Abnormal bleeding
- AIDS or HIV infection
- Anemia
- Arthritis
- Asthma
- Blood transfusion
  If yes, date _____
- Cancer/Chemotherapy/ radiation treatment
- Cardiovascular disease
  If yes, specify below:
  - ☐ Angina
  - ☐ Artificial heart valves
  - ☐ Heart attack
  - ☐ Heart murmur
  - ☐ High blood pressure
  - ☐ Mitral valve prolapse
  - ☐ Pacemaker
  - ☐ Rheumatic heart disease
  - ☐ Other _____

Yes No Don't know

- Disease, drug or radiation-induced immunosuppression
- Diabetes. If yes, specify:
  - Type I (insulin dependent)
  - Type II
- Dry mouth
- Eating disorder
  If yes, specify _____
- Epilepsy
- Fainting spells or seizures
- Hemophilia
- Hepatitis, jaundice, liver disease
- Recurrent infections
  Indicate type of infection
- Kidney problems
- Low blood pressure
- Mental health disorders
  If yes, specify below:

Yes No Don't know

- Rapid weight loss
- Sexually transmitted diseases
- Sinus trouble
- Sores/ulcers in mouth
- Stroke
- Systemic lupus erythematous
- Thyroid problems
- Tuberculosis
- Excessive urination
- Do you have any other diseases or conditions not listed? If yes, please explain.
- Persistent diarrhea
- Migraines
- Persistent swollen glands in neck
- Chest pain upon exertion
- Chronic pain
- Respiratory problems

- Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If so, when? _____
  If yes, has a physician or previous dentist recommended that you take antibiotics prior to your treatment? If so, what antibiotic and what dose? _____

Women only:

- Are you pregnant?
- Are you nursing?
- Are you currently using any form of birth control (pill, patch, shot, etc)? Please explain _____

I certify I have read and understand the above. I acknowledge my questions, if any, about inquiries set forth above have been answered to my satisfaction. I won't hold Sandburg students, faculty or staff responsible for any action they take or don't take because of errors or omissions I may have made in the completion of this form.

_____ Signature of patient/guardian **(over age 18)**

_____ Date

	BP	Student	Faculty
1			
2			

Updated health history & blood pressure

	Date	Pt. Init.	BP	Student	Faculty		Date	P.I.	BP	St.	Fac.		Date	P.I.	BP	St.	Fac.
3						5						7					
4						6						8					