Mohn Family Dental

Health History Form

Insurance Information

Who is responsible for this account? _____

Relationship to patient:_____

Insurance Company:_____

Employer: _____

Group number: _____ ID Number: _____

Is patient covered by additional insurance? _____

Subscribers name: _____

Birthday: _____ Social Security #: _____

Relationship to patient _____

Insurance Company:_____

Employer: _____

Group Number: _____ ID Number: _____

General Information

Name: *Last* *First* *Middle*

Home Phone: *Include Area Code* ( )

Business/Cell Phone: *Include Area Code* ( )

Address:

City:

State:

Zip:

Occupation:

Height:

Weight:

Date of Birth:

Sex: M F

SS# or Patient ID:

Emergency Contact:

Relationship:

Home Phone: ( )

Cell Phone: ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name *Relationship*

Please specify your preferred method of contact *(circle one)* **Call** **Text** **Email**

Cell phone carrier:

Preferred Phone Contact:

Email:

Allergies

Are you allergic to ot have you had a reaction to any of the following:
*To all **yes** responses, specify type of reaction.*

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Other _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/Seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐

Heart Problems

Please mark (X) to inficate if you have had any of the following diseases or problems.

	Yes	*No*	*DK*
Artificial/prosthetic heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)	☐	☐	☐
Unrepaired, cyanotic CHD.	☐	☐	☐
Repaired (completely) in last 6 months.	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

WOMEN ONLY Are you:	Yes	No	DK
Pregnant?	☐	☐	☐
Number of weeks: _____			
Nursing?	☐	☐	☐
Taking birth control pills or hormonal replacement?	☐	☐	☐

Joint Replacement	Yes	No	DK
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking, or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Atelvia, Boniva, Prolia)?	☐	☐	☐
Have you ever been treated or are you scheduled to begin treatment with an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer?	☐	☐	☐
Date treatment began: _____			

Please list all medications you are currently taking in the space provided below:

_____

_____

FOR COMPLETION BY DENTIST

Comments: _____

_____

Dental Information

For the following questions, please mark (X) for your response.

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets, or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal surgery?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Are you currently experiencing dental pain or discomfort?	☐	☐	☐
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping, or discomfort in the jaw?	☐	☐	☐
Do you grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information

For the following questions, please mark (X) for your response.

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone:

Address/City/State/Zip

Are you in good health?	☐	☐	☐
Has there been any changes in your health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam: _____

Have you had a serious illness, operation, or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Do you wear contact lenses?	☐	☐	☐
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐

If so, are you interested in stopping?

Circle one: **Very** **Somewhat** **Not Interested**

Do you drink alcoholic beverages?	☐	☐	☐

If yes, how much did you drink in the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

Diseases & Problems

Please mark (X) in response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Eating disorder	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Osteoporosis	☐	☐	☐
Severe/rapid weight loss	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells/seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
Specify: _____			
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Recurrent infections	☐	☐	☐
Type of infection _____			
Mental health disorders	☐	☐	☐
Specify: _____			
Arthritis	☐	☐	☐
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Chronic pain	☐	☐	☐
Pace maker	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
if yes, date _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Severe headaches/migranes	☐	☐	☐
Excessive urination	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Asthma	☐	☐	☐

Do you have any of the following diseases or problems:

Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with Tuberculosis	☐	☐	☐
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation: Phone: ( )

Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

Please explain:

Note: Both doctor 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 information given on this form is accurate. I understand the importance of a truthful health history and that my dentist/staff will rely on this information when treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other staff member 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:

Signature of Dentist: Date: