Gaslight Village Family Dentistry
Health History Form

DATE: *HOW DID YOU HEAR OF US?*

Name:	Home Phone:		Cell Phone:
Address:	City:	State:	Zip:
Occupation	Date Of Birth:	Sex: M F	E-mail:
SSN:	Emergency Contact:	Relationship:	Contact Number:

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

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions. **Note: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**

Dental Information

	Yes	No	?
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Do you experience dry mouth?	☐	☐	☐
Have you had any Periodontal (gum) treatments?	☐	☐	☐
Have you had any Orthodontic (braces) treatment?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear partial or full dentures?	☐	☐	☐
Have you ever had any problems with dental treatment?	☐	☐	☐
Are you experiencing any dental pain or discomfort?	☐	☐	☐
Are you happy with your smile?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
Do you have earaches or neck pain?	☐	☐	☐
Do you have any clicking, popping, or discomfort in the jaw?	☐	☐	☐
Do you clench or grind your teeth?	☐	☐	☐

Have you ever had a head, neck or mouth injury? ____________

Date of your last Dental X-rays/ Exam? _____________________

What is the reason for your visit today? _____________________

Medical Information

	Yes	No	?
Are you currently under the care of a physician?	☐	☐	☐
Physician's name and phone number: ____________________________			
Are you in good health?	☐	☐	☐
Any changes in your general health in the past year?	☐	☐	☐
Have you had a serious illness, operation, or been hospitalized in the past 5 years?	☐	☐	☐
If yes explain? ____			
Are you taking, or have you recently taken any prescription or over the counter medications?	☐	☐	☐
If yes what? ____			
Are you taking, or have you taken any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine), or Phen- Fen (fenfluramine-phentermine combination)?	☐	☐	☐
Are you taking either Alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, have you been treated with bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting in Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Do you used controlled substances (Drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
Do you drink alcoholic beverages?	☐	☐	☐
Women Only:			
Are you pregnant, trying to get pregnant or nursing?	☐	☐	
Number of weeks:			

Allergies:

Are you allergic to or have you had a reaction to any of the following?

	Yes	No	?
Local anesthetics	☐	☐	☐
If yes what? ______			
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives or sleeping pills	☐	☐	☐
Sulfa Drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Metals	☐	☐	☐
If yes what? ______			
Latex (Rubber)	☐	☐	☐

Allergies continued :

	Yes	No	?
Lodine (Etodolac)	☐	☐	☐
Hay Fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Gluten	☐	☐	☐
Other	☐	☐	☐
If yes what? ______			

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

______

Do you have any diseases, conditions, or problems not listed that you think we should know about?

______

Please mark (x) to indicate if you have had any of the following:

	Yes	No	?
Artificial Heart Valve	☐	☐	☐
Artificial Joint	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Abnormal Bleeding	☐	☐	☐
Anemia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune Disease	☐	☐	☐
Asthma	☐	☐	☐
Abnormal Blood Pressure (Low or High)	☐	☐	☐
Blood Disease	☐	☐	☐
Blood Transfusion	☐	☐	☐
Bronchitis	☐	☐	☐
Cardiovascular disease	☐	☐	☐
Congestive Heart Failure	☐	☐	☐
Coronary Artery Disease	☐	☐	☐
Congenital Heart Defects	☐	☐	☐
Cancer / Chemotherapy / Radiation Treatment	☐	☐	☐
Chronic Pain	☐	☐	☐
Damaged Heart Valves	☐	☐	☐
Diabetes Type 1 or 2	☐	☐	☐
Eating Disorder	☐	☐	☐

	Yes	No	?
Epilepsy	☐	☐	☐
Fainting Spells or seizures	☐	☐	☐
Frequent cough (lasting longer than two weeks)	☐	☐	☐
G.E Reflux / Persistent heartburn	☐	☐	☐
Gastrointestinal Disease	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis A	☐	☐	☐
Hepatitis B or C	☐	☐	☐
Hemophilia	☐	☐	☐
Herpes	☐	☐	☐
Heart Murmur	☐	☐	☐
Jaundice or Liver Disease	☐	☐	☐
Mitral Valve Prolapse	☐	☐	☐
Mental Health Disorders	☐	☐	☐
Neurological Disorders	☐	☐	☐
Osteoporosis	☐	☐	☐
Pain in Jaw Joints	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Pacemaker	☐	☐	☐
Recurrent Infections	☐	☐	☐
Shingles	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Sinus Trouble	☐	☐	☐
Tonsillitis	☐	☐	☐

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for 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 member of his/ her staff, 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: ______