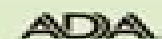


Health History Form



American Dental Association
www.ada.org

E-mail:

Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: Last First Middle		Home Phone: include area code ()		Business/Cell Phone: include area code ()	
Address: Mailing address		City:		State: Zip:	
Occupation:		Height:		Weight:	
		Date of birth:		Sex: M F	
SSN or Patient ID:		Emergency Contact:		Relationship:	
		Home Phone: ()		Cell Phone: ()	
				include area codes	
If you are completing this form for another person, what is your relationship to that person?					
Your Name		Relationship			
Do you have any of the following diseases or problems: (Check DK if you Don't Know the answer to the question)					
Active Tuberculosis				Yes	No DK
Persistent cough greater than a 3 week duration				☐	☐
Cough that produces blood				☐	☐
Been exposed to anyone with tuberculosis				☐	☐
If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.					

Dental Information

For the following questions, please mark **DO** your responses to the following questions.

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐	Do you have earaches or neck pains?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐	Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐	Do you brux or grind your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐	Do you have sores or ulcers in your mouth?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐	Do you wear dentures or partials?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐	Do you participate in active recreational activities?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐	Have you ever had a serious injury to your head or mouth?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐	Date of your last dental exam:			
Do you drink bottled or filtered water?	☐	☐	☐	What was done at that time?			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY				Date of last dental x-rays:			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐				
What is the reason for your dental visit today?							
How do you feel about your smile?							

Medical Information

Please mark **DO** your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK		Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐	Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐
Physician Name:				If yes, what was the illness or problem?			
Phone: include area code ()							
Address/City/State/Zip:				Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐
Are you in good health?	☐	☐	☐	If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:			
Has there been any change in your general health within the past year?	☐	☐	☐				
If yes, what condition is being treated?							
Date of last physical exam:							

Sample Nursing Health History Form

Kimberly A. Galt, Galt



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Basic Concepts of Psychiatric-mental Health Nursing Louise Rebraca Shives, 2007 This seventh edition includes new chapters and maintains popular features from previous editions such as self awareness prompts while adding research boxes and student worksheets at the end of each chapter

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Nurse's Handbook of Health Assessment Janet R Weber, RN Edd, 2013-11-18 Renowned for its holistic perspective and step by step approach this pocket size text takes you through every stage of the nursing assessment for adults and special populations The book s see and do guidance provides all that you need to perform a range of common assessment procedures with confidence

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Community Health Nursing for Working People United States. Bureau of Occupational Safety and Health, 1970

Health Information Technology

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Maternity, Newborn, and Women's Health Nursing Susan A. Orshan, 2008 This new book will be a core text for undergraduate Maternity Newborn courses It also will work for courses emphasizing Women s Health across the lifespan Coverage includes core content on preconception pregnancy labor birth and postpartum In addition the text focuses on important topics throughout a woman s life health promotion nutrition medical issues psychosocial issues sexuality family fertility control and issues menopause and aging While other texts touch on the different stages of a woman s lifespan this book provides more detail and information in areas outside the average maternity text

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