

Health History Form

E-mail:

Today's Date:



American Dental Association
www.ada.org

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:		Home Phone: include area code		Business/Cell Phone: include area code	
Last	First	Middle	()	()	()
Address:			City:	State:	Zip:
Mailing address:					
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

Christian G. Meyer



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