Health History Form

GLENN L. SANDS DDS
COSMETIC AND FAMILY DENTISTRY

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.

Patient Name:_____

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

Relationship: _____Your name: _____

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?	☐	☐
Is your mouth dry?	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐
Have you had any problems associated with previous treatments?	☐	☐
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?	☐	☐

	YES	NO
Do you brux or grind your teeth?	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐
Do you wear dentures or partials?	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐

Date of last dental exam:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information

	YES	NO
Physician Name:		
Phone Number:		
Are you in good health?	☐	☐
Has there been any changes in your health within the past year?	☐	☐
If yes, what is the condition being treated?: _____		
_____		
Joint replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger, etc.) replacement?	☐	☐
Date:_____		
If yes, have you had any complications?_____		
_____		
Are you taking or scheduled to begin taking either of the medications, Alendronate (Fosamax) or Risedronate (Actonel) for osteoporosis or Paget's disease?	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypocalcaemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐
Date treatment began:_____		

	YES	NO
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐
If yes, what was the illness or problem?_____		
_____		
_____		
Are you taking or have you recently taken any medicines, including prescription and over the counter medications?	☐	☐
If yes, please list all:_____		
_____		
_____		
_____		
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐
Do you use controlled substances (drugs)?	☐	☐
Do you have a history of substance abuse and/or alcoholism?	☐	☐
If yes, please list:_____		
WOMEN ONLY:		
Are you taking birth control pills or hormonal replacement?	☐	☐
Are you pregnant?	☐	☐
If yes, how many weeks?_____		
Are you currently nursing?	☐	☐

Medical Information

Medical Conditions	YES	NO
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	☐	☐

	YES	NO
Cardiovascular disease	☐	☐
Angina	☐	☐
Arteriosclerosis	☐	☐
Congestive heart failure	☐	☐
Damaged heart valves	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Low blood pressure	☐	☐
High blood pressure	☐	☐

	YES	NO
Other congenital heart defects	☐	☐
Mitral valve prolapse	☐	☐
Pacemaker	☐	☐
Rheumatic fever	☐	☐
Rheumatic heart disease	☐	☐
Abnormal bleeding	☐	☐
Anemia	☐	☐
Hemophilia	☐	☐

	YES	NO
Blood Transfusion	☐	☐
Date: _____		
AIDS/HIV infection	☐	☐
Arthritis	☐	☐
Autoimmune disease	☐	☐
Rheumatoid arthritis	☐	☐
Systemic lupus erythematosus	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Sinus Trouble	☐	☐
Tuberculosis	☐	☐
Cancer/Chemotherapy/ radiation treatment	☐	☐
Chest pain upon exertion	☐	☐
Diabetes Type I or II	☐	☐
Eating Disorder	☐	☐
Thyroid problems	☐	☐

	YES	NO
Gastrointestinal disease	☐	☐
GE Reflux/persistent heartburn	☐	☐
Hepatitis, jaundice or liver disease	☐	☐
Epilepsy	☐	☐
Neurological disorders	☐	☐
If yes, specify _____		
Sleep disorder.	☐	☐
Mental health disorders	☐	☐
If yes, specify _____		
Kidney Problems	☐	☐
Osteoporosis	☐	☐
Persistent swollen glands in neck	☐	☐
Severe headaches/migraines	☐	☐
Sexually transmitted disease	☐	☐

Has a physician or previous dentist recommended that you take antibiotics (pre-medicate) 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 we should know about? ☐ ☐

If yes, please explain:_____

Allergies: Are you allergic to or have you had a reaction to:	YES	NO
Local Anesthetics	☐	☐
Aspirin	☐	☐
Penicillin or other antibiotics	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Sulfa drugs	☐	☐

Codeine & other narcotics	☐	☐
Ibuprofen	☐	☐
Metals	☐	☐
Latex(rubber)	☐	☐
Iodine	☐	☐
List all other allergies_____		

Note: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

HEALTH QUESTIONAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED: I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Glenn L. Sands and/or assistants as he may designate to perform those procedures as any be deemed necessary or advisable to maintain my dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to, bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness, and muscle soreness. I do voluntarily assume any and all possible risks, associated with general preventative and operative treatment procedures in hope of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the forgoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signature:	Date:
Witness:	Date:
Signature:	Update:
Signature:	Update: