Health Assessment Form - 2014

Patient Name: Birth Date: Date Created:

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.

Are you under a physician's care now? ◯ Yes ◯ No If yes

Have you ever been hospitalized or had a major operation in the last 5 years? ◯ Yes ◯ No If yes

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes

Are you taking any prescribed medications or OTC supplements/medications? ◯ Yes ◯ No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No If yes

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous ◯ Yes ◯ No

Do you use tobacco (cigarettes, cigars, snuff, ◯ Yes ◯ No

Do you drink alcoholic beverages? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you...

- ☐ Pregnant?
- ☐ Nursing?
- ☐ Taking oral contraceptives?
- ☐ Trying to get pregnant?
- ☐ Taking hormone replacement?

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine or other narcotics
- ☐ Acrylic
- ☐ Metals
- ☐ Latex (rubber)
- ☐ Sulfa Drugs
- ☐ Local Anesthetics
- ☐ Barbiturates, sedatives, or sleeping pil
- ☐ Iodine
- ☐ Hay fever/seasonal
- ☐ Animals
- ☐ Food

Do you have any other allergies not previously ◯ Yes ◯ No If yes

Do you have or have you had, any of the following?

Artificial (prosthetic) heart valve? ◯ Yes ◯ No

Previous infective endocarditis? ◯ Yes ◯ No

Damaged valves in transplanted heart? ◯ Yes ◯ No

Congenital Heart Disease ◯ Yes ◯ No

Unrepaired cyanotic CHD? ◯ Yes ◯ No

Completely repaired CHD in last 6 months ◯ Yes ◯ No

Repaired CHD with residual defects? ◯ Yes ◯ No

Do you have, or have you had, any of the following?

Condition	Yes / No	Condition	Yes / No	Condition	Yes / No	Condition	Yes / No
Asthma	◯ Yes ◯ No	Night sweats	◯ Yes ◯ No	Bronchitis	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Emphysema	◯ Yes ◯ No	Persistent swollen glands in neck	◯ Yes ◯ No	Sinus trouble	◯ Yes ◯ No	Headaches or migraines	◯ Yes ◯ No
Tuberculosis	◯ Yes ◯ No	Severe or rapid weight loss	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No	Sexually transmitted disease	◯ Yes ◯ No
Radiation Treatment	◯ Yes ◯ No	Excessive urination	◯ Yes ◯ No	Cardiovascular disease	◯ Yes ◯ No	Chest pain upon exertion	◯ Yes ◯ No
Excessive Bleeding	◯ Yes ◯ No	Angina	◯ Yes ◯ No	Chronic pain	◯ Yes ◯ No	Joint replacement	◯ Yes ◯ No
Athlerosclerosis	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Congestive heart failure	◯ Yes ◯ No	Eating disorder	◯ Yes ◯ No
Damaged heart valves	◯ Yes ◯ No	Gastrointestinal Disease	◯ Yes ◯ No	Heart attack	◯ Yes ◯ No	G.E. reflux/persistent heartburn	◯ Yes ◯ No
Low blood pressure	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No	High blood pressure	◯ Yes ◯ No	Thyroid disease	◯ Yes ◯ No
Pacemaker	◯ Yes ◯ No	Stroke	◯ Yes ◯ No	Abnormal bleeding	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Hepatitis,jaundice or liver disease	◯ Yes ◯ No	Blood transfusion	◯ Yes ◯ No	Epilepsy	◯ Yes ◯ No
Tonsillitis	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Fainting or seizures	◯ Yes ◯ No	AIDS or HIV infection	◯ Yes ◯ No
Neurological disorders	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Arthritis	◯ Yes ◯ No	Sleep disorder	◯ Yes ◯ No
Autoimmune disease	◯ Yes ◯ No	Mental health disorder	◯ Yes ◯ No	Rheumatoid arthritis	◯ Yes ◯ No	Recurrent infections	◯ Yes ◯ No
Systemic lupus erythematosus	◯ Yes ◯ No	Kidney disease	◯ Yes ◯ No	Autism spectrum disorder	◯ Yes ◯ No	Attention deficit disorder	◯ Yes ◯ No
Parathyroid disease	◯ Yes ◯ No						

Have you ever had any serious illness not listed ◯ Yes ◯ No If yes

Dental Information

Question	Yes / No
Are your teeth sensitive to cold, hot, sweets or	◯ Yes ◯ No
Does food or floss catch between your teeth?	◯ Yes ◯ No
Is your mouth dry?	◯ Yes ◯ No
Have you ever had orthodontic treatment (braces)?	◯ Yes ◯ No
Have you had any concerns associated with previous dental treatment?	◯ Yes ◯ No
Are you currently experiencing dental pain or	◯ Yes ◯ No
Do you have earaches or neck pain?	◯ Yes ◯ No
Do you have any clicking, popping or discomfort in	◯ Yes ◯ No
Do you clench or grind your teeth?	◯ Yes ◯ No
Do you have any sores or ulcers in your mouth?	◯ Yes ◯ No
Do you wear dentures or partials?	◯ Yes ◯ No
Have you had any periodontal (gum) treatments?	◯ Yes ◯ No
Do you participate in active recreational activities?	◯ Yes ◯ No
Do you snore?	◯ Yes ◯ No
Do you use or are you supposed to use a CPAP?	◯ Yes ◯ No
Have you been diagnosed with sleep apnea?	◯ Yes ◯ No

Smile Evaluation

Do you have concerns about the following?

Concern	Yes / No
Missing teeth you would like replaced	◯ Yes ◯ No
Old fillings you would like replaced	◯ Yes ◯ No
Desire for your teeth to be whiter	◯ Yes ◯ No
White or brown spots on teeth	◯ Yes ◯ No
Gummy smile	◯ Yes ◯ No
I hate how my teeth look! Please help!	◯ Yes ◯ No
Spaces between teeth	◯ Yes ◯ No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. I will not hold the dentist or any 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 completion of this form. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:___________