Advanced Dental Practices

21 East St., Wrentham, MA 02093
Phone 508-384-3760 Fax 508-384-5083

Health History Form

Email:..... Cell: (.....)..... Today's date:.....
How did you hear about us? (for new patients only) .....

The following information is vital to allow us to provide appropriate care for you. Your information will be kept confidential subject to applicable laws.

Last Name:.....First Name..... MI..... Home Phone:(.....).....
Address:.....City:.....State: .....Zip: .....

Date of Birth:.....Gender: **M** **F** SSN:.....-.....-..... Height:..... Weight:.....
(Required for insurance claims)
Occupation:.....Emergency contact:.....Relationship:.....Phone:.....
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 conditions:	**(Check DK if you don't know)**	**Y**	**N**	**DK**
Active Tuberculosis (TB)		☐	☐	☐
Persistent cough for over 3 weeks		☐	☐	☐
Cough that produces blood		☐	☐	☐
Are you under a Primary Physician's care?		☐	☐	☐
Have you been recently hospitalized?		☐	☐	☐
Do you use tobacco?		☐	☐	☐
Do you use controlled substances(please specify)?		☐	☐	☐
Do you use medicinal or recreational Marijuana (please specify)?		☐	☐	☐
Do you take, or have taken, oral or IV Bisphosphonates like Boniva, Fosamax, Actonel or any other medication for Osteoporosis?		☐	☐	☐

Dental Information

	(Check DK if you don't know)	**Y**	**N**	**DK**
Do your gums bleed while brushing or flossing?		☐	☐	☐
Are your teeth sensitive to hot, cold, sweet or pressure?		☐	☐	☐
Do you grind/clench your teeth during the day or night (please specify)?		☐	☐	☐
Do you have any jaw pain?		☐	☐	☐
Do you experience any clicking or popping of the TMJ?		☐	☐	☐
Do you wear a Night Guard?		☐	☐	☐
Do you wear Dentures (full or partials)?		☐	☐	☐

Date of last dental visit: ..... Date of last dental X-rays:.....

Are you **allergic** to any medications? Please list:……

Please list all medications you are **taking** (including supplements):……

……

*DO NOT DISCONTINUE ANY MEDICATION WITHOUT CONSULTING YOUR PHYSICIAN

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

	Y	N		Y	N		Y	N		Y	N
Cardiovascular Disease			Hemophilia			GI Disease			Convulsions		
Heart Attack			Bld. Transfusion			Gastric Ulcers			Headaches/Migraines		
Stroke			Blood Disorder			Malnutrition			Psychiatric Condition		
Congest. Heart Failure			HIV/AIDS			Eating Disorder			Glaucoma		
Congenital Heart Dis.			Autoimmune Dis.			Thyroid Disease			Osteoporosis		
Heart Murmur			Osteoarthritis			Kidney Disease			Rapid Weight Loss		
Low Blood Pressure			Rheum. Arthritis			Alcoholism			STD		
High Blood Pressure			Lupus			Drug Addiction			Night Sweats		
Mitral Valve Prolapse			Bronchitis			Diabetes- I & II			Excessive Urination		
Pacemaker			Asthma			Cancer			Smoking		
Artificial Heart Valve			COPD			Chemotherapy			Shingles		
Rheumatic Fever			Emphysema			Radiation			Artificial Joints		
Rheum. Heart Disease			Chr. Liver Dis.			Epilepsy			Alzheimer's Disease		
Anemia			Hepatitis			Fainting/Dizziness			Hay Fever		
Excessive Bleeding			Cirrhosis			Seizures			Cortisone Therapy		

Any other illness that is not listed above? If yes, please explain:……

……

For women only- Are you:

Pregnant/Trying to get pregnant **Y** **N** Nursing **Y** **N** Taking oral contraceptives **Y** **N**

Acknowledgement

I have accurately answered the above questions to the best of my ability. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform Advanced Dental Practices of any changes in the medical status.

Print Name:_____ Signature:_____

Parent or Guardian Signature:_____ Date:_____

Doctor's Signature:_____ Date:_____