Dobbs Ferry Family Dental

DFFD

Health History Form

Last Name_____

First Name_____M_____

DOB_____/_____/_____ ❑ Male ❑ Female

SS#_____

Height_____ Weight _____ ❑Single ❑Married

Occupation_____

Referred By: _____

Today's Date_____

Address_____

City_____State____ Zip_____

Home Phone_____

Cell Phone _____

E-mail _____

Emergency Contact_____

Relationship_____

Phone#_____

Dental Information For the following questions mark (x) for yes or no

	Yes	No
Do you have dry mouth?	❑	❑
Do your gums bleed when you brush or floss?	❑	❑
Are your teeth sensitive to cold, hot, sweet or pressure?	❑	❑
Do you drink bottled or filtered water?	❑	❑
Are you currently experiencing dental pain or discomfort?	❑	❑
Do you have earaches or neck pains?	❑	❑
Do you have any discomfort in the jaw joint?	❑	❑
Do you grind your teeth?	❑	❑
Do you have sores/ulcers in your mouth?	❑	❑
Do you wear dentures or partials?	❑	❑
Have you had any serious injury to your head or mouth?	❑	❑

What is the reason for your dental visit today?

_____

Date of your last dental exam_____

What was done at that time_____

_____

Date of your last dental x-rays_____

Medical Information For the following questions mark (x) for yes or no

	Yes	No
Have you had a serious illness, operation or been hospitalized in the past 5 years?	❑	❑
Are you taking or have you recently taken any prescription medications?	❑	❑

Physician Name_____

Phone #_____

Address/City/State/Zip

_____

_____

Date of your last physical exam?_____

What conditions if any are you being treated for?_____

_____

If yes, what was the illness or problem?_____

_____

If yes, please list all, including vitamins, or herbal preparations and supplements. Describe the conditions for which you take prescription medications.

_____

_____

(OVER)

Medical Information

	Yes	No
Do you wear contact lenses?	❑	❑
Do you take or have you taken Phen-Fen, Redux or any other diet medications?	❑	❑
Have you ever taken Fosamax, or Actonel for osteoporosis or Paget's disease?	❑	❑
Do you use controlled substances (drugs)?	❑	❑
Do you use tobacco (smoking, snuff, chew)?	❑	❑
Do you drink alcoholic beverages?	❑	❑

Allergies. Are you allergic to any of the following?
If **yes**, specify type of reaction

Local Anesthetics ❑ Advil, Tylenol ❑ Aspirin ❑
Antibiotics ❑ Codeine ❑ Other ❑

WOMEN ONLY Are you:	Yes	No
Pregnant?	❑	❑
Taking birth control pills?	❑	❑
Nursing?	❑	❑

Please mark (x) your response if you have any of the following conditions

❑ Joint Replacement ❑ Artificial heart valve ❑ Rheumatic fever	❑ Cancer	❑ Glaucoma	❑ Mental Illness
❑ AIDS/HIV	❑ Chemo or Radiation	❑ Hay Fever	❑ Recent Weight Loss
❑ Alzheimer's Disease	❑ Chest Pains	❑ Heart Disease	❑ Respiratory Disease
❑ Angina	❑ Convulsions	❑ Hemophilia	❑ Shingles
❑ Arthritis/Gout	❑ Diabetes	❑ Hepatitis A, B or C	❑ Sickle Cell Disease
❑ Asthma	❑ Emphysema	❑ High Blood Pressure	❑ Sinus Trouble
❑ Blood Disease/Anemia	❑ Epilepsy or Seizures	❑ High Cholesterol	❑ Spina Bifida
❑ Blood Transfusion	❑ Excessive Bleeding	❑ Hives or Rash	❑ STDs
❑ Bruise Easily	❑ Excessive Thirst	❑ Hypoglycemia	❑ Stroke
	❑ Fainting Spells/Dizziness	❑ Kidney Problems	❑ Thyroid Disease
	❑ Frequent Cough	❑ Liver Disease	❑ Tuberculosis
	❑ Frequent Diarrhea	❑ Low Blood Pressure	❑ Tumors or Growths
	❑ Oral/Genital Herpes	❑ Lung Disease	❑ Other

Have you had any serious illness not listed above? If **yes,** please explain_____

Comments:_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient or Gaurdian_____ Date_____

For completion by the dentist.
Significant findings from questionnaire:_____

_____

_____

Signature of Dentist_____ Date_____