

Health History Form

In order to provide you with the best care possible, please fill out our medical history form and advise us of any changes in your medical history at each visit. You can also attach a list of your medications and supplements to this form.

PLEASE PRINT UNLESS OTHERWISE INDICATED & CIRCLE ANSWERS AS NEEDED

ABOUT YOU

Today's Date: _____ Email Address: _____

First Name: _____ MI: _____ Last Name: _____

Nickname _____ Male / Female Mr. / Mrs. / Ms. / Dr.

Marital Status: Single / Married / Divorced / Legally Separated / Widowed

Birthdate: _____ / _____ / _____ Age: _____ Social Security #: _____ / _____ / _____
Month Day Year

Employer: _____ Employer's Address: _____

Occupation: _____

Full Home Address: _____

Mailing Address (if different from home address): _____

Telephone: Home _____ Cell _____

Work _____ Ext. _____

Where & when are the best times to reach you? _____

Do we have your permission to leave a message (voicemail or with person answering phone)? Y N

Signature Required: _____

SPOUSE INFORMATION

His/Her Full Name: _____

Social Security #: _____ / _____ / _____

Employer: _____

Telephone: Home _____ Cell _____

Work _____ Ext. _____

PERSON RESPONSIBLE FOR ACCOUNT

First Name: _____ MI: _____ Last Name: _____

Relationship: Self / Spouse / Father / Mother / Other (Please specify) _____

Billing Address: _____

Birthdate: _____ / _____ / _____ Age: _____ Social Security #: _____ / _____ / _____
Month Day Year

Email: _____

Employer: _____

Telephone: Home _____ Cell _____

Work _____ Ext. _____

Do you have Dental Coverage: Y N

EMERGENCY CONTACT INFORMATION

In the event of an emergency, who you would like for us to contact: _____

Relation: _____

Telephone: Home _____ Cell _____

Work _____ Ext. _____

DENTAL HISTORY

- Do you require antibiotics before dental treatment? Y N
- Are you currently in pain? Y N
- Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Y N
- Your current dental health is: Good / Fair / Poor
- Have you ever had a serious/difficult problem associated with any previous dental work? Y N
- Brief explanation: _____

- Do you like your smile? Y N
- Would you like whiter teeth? Y N
- Would you like fresher breath? Y N
- How many times a week do you:
 - brush _____ floss _____
- Type of bristles used? Soft / Medium / Hard
- Do you snore? Y N
- Do you smoke or use tobacco in any form? Y N
- If "Yes", form used: _____

MEDICAL HISTORY

Do you have a personal physician? Y N

Physician's Name: _____ Physician's Phone #: (____) _____

Date of last visit: _____

Are you currently under the care of a physician? Y N

Please explain: _____

Your current physical health is: Good / Fair / Poor

Have you ever taken Fosamax, or any other bisphosphonate? Y N

If "Yes", when did you start _____ Are you taking it now? Y N

FOR WOMEN

Are you using a prescribed method of birth control? Y N

Are you pregnant? Y N

If "Yes", how many weeks? _____

Are you nursing? Y N

Please mark any of the following conditions or medical problems you have/have had:

- | | | |
|---|--|---|
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Artificial Bones/Joints/Valves | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Rheumatic / Scarlet Fever |
| ↳ What type: _____ | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Sickle Cell Disease/Traits |
| <input type="checkbox"/> Cancer/Chemotherapy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Herpes/Fever Blisters | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV+ / AIDS | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | |

Please mark any of the following you are allergic to:

- | | | |
|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Metals | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Jewelry | |

Are you taking any prescription medications, over-the-counter medications, or supplements of any kind? Y N
List each prescription and dosage currently taking:

Do you have or have you ever had MRSA (Staph)? Y N If "Yes", when did you have it and do you have it now?

If you currently infected, are you being treated by a physician? Y N Name of Physician: _____

Please list any serious medical conditions that you have ever had: _____

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Dr. Jackson Hanigofsky
Health History Form

Name of patient here: _____

I verbally reviewed the medical/dental information above with the patient named herein.

Initials _____ Date: _____

Doctor's Comments:

MEDICAL HISTORY UPDATE

Date: _____ Comments: _____

Signature: _____

Date: _____ Comments: _____

Signature: _____