

# HEALTH HISTORY



Patient Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Medical Doctor \_\_\_\_\_ M.D. Phone No. \_\_\_\_\_

Is your general health good? \_\_\_\_\_

Do you have an existing illness? \_\_\_\_\_

Has there been a change in your health in the last year? \_\_\_\_\_

Have you been hospitalized in the last year? \_\_\_\_\_ If yes, why? \_\_\_\_\_

Have you taken Fen Phen? \_\_\_\_\_

Do you take or have you had Bisphosphonate therapy? (i.e. Boniva, Fosomax, Skeli, Actonal) \_\_\_\_\_

What medications are you taking at this time? \_\_\_\_\_

Have you had joint replacement? \_\_\_\_\_

Do you have an artificial heart valve? \_\_\_\_\_

Do you have a history of infective endocarditis? \_\_\_\_\_

Have you had a cardiac transplant that developed cardiac valvulopathy? \_\_\_\_\_

Do you have congenital heart defects, repaired or unrepaired? If so explain. \_\_\_\_\_

Are you allergic to latex? \_\_\_\_\_

Are you allergic to any medications? \_\_\_\_\_ Which drugs or medications? \_\_\_\_\_

Are you allergic to metals or jewelry? \_\_\_\_\_

WOMEN ONLY: Are you pregnant or nursing? \_\_\_\_\_ Do you take birth control pills? \_\_\_\_\_

Please circle if you have had or have at the present time any of the following:

- |                             |                                   |                            |                                |
|-----------------------------|-----------------------------------|----------------------------|--------------------------------|
| <b>Chest Pain</b>           | <b>Swollen Ankles</b>             | <b>Shortness of Breath</b> | <b>Stroke</b>                  |
| <b>Recent Weight Loss</b>   | <b>Persistent Cough</b>           | <b>Bleeding Problems</b>   | <b>Herpes</b>                  |
| <b>Sinus Problems</b>       | <b>Difficulty Swallowing</b>      | <b>Nausea</b>              | <b>Thyroid Disease</b>         |
| <b>Difficulty Urinating</b> | <b>Blood In Urine</b>             | <b>Dizziness</b>           | <b>High Blood Pressure</b>     |
| <b>Ringling In The Ears</b> | <b>Headaches</b>                  | <b>Seizures</b>            | <b>Stomach Problems/Ulcer</b>  |
| <b>Blurred Vision</b>       | <b>Fainting Spells</b>            | <b>Excessive Thirst</b>    | <b>Diabetes</b>                |
| <b>Frequent Urination</b>   | <b>Dry Mouth</b>                  | <b>Jaundice</b>            | <b>Hepatitis/Liver Disease</b> |
| <b>Joint Pain</b>           | <b>Asthma, Tb, Emphysema</b>      | <b>Heart Disease</b>       | <b>Kidney Disease</b>          |
| <b>Aids/HIV Positive</b>    | <b>Heart Attack/Heart Defects</b> | <b>Tumors/Cancer</b>       | <b>Radiation Treatment</b>     |
| <b>Heart Murmur</b>         | <b>Arthritis/Rheumatism</b>       | <b>Rheumatic Fever</b>     |                                |
| <b>Eye Disease</b>          | <b>Skin Disease</b>               | <b>Anemia</b>              |                                |

Do you have or have you had any other disease or medical problem not listed on this form?

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

## RECALL REVIEW

1. Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

2. Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

3. Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

# DENTAL HISTORY



Date \_\_\_\_\_

Are you in pain today? \_\_\_\_\_

Do you have any present dental complaints? \_\_\_\_\_ Explain \_\_\_\_\_

Name of previous dentist? \_\_\_\_\_ Phone number or city \_\_\_\_\_

Are you happy with your smile? \_\_\_\_\_

When was your last full mouth set of x-rays taken? \_\_\_\_\_

When was your last cleaning? \_\_\_\_\_

Do you need to take Pre-Med? \_\_\_\_\_

Have you had any serious trouble with previous dental treatment? \_\_\_\_\_ Explain \_\_\_\_\_

Have you had any problems with local dental anesthesia? \_\_\_\_\_

*Please circle if you have had or have at the present time any of the following:*

**Abcess In Mouth**

**Bad Tastes In Mouth**

**Blisters On Lips Or In Mouth**

**Clenching/Grinding Teeth**

**Dry Mouth**

**Loose Teeth**

**Pain In Jaw Joint**

**Stained Teeth**

**Any Food Traps**

**Bite Nails**

**Chew On One Side Only**

**Cold Sores**

**Gag Easily**

**Missing Teeth**

**Sensitive Teeth**

**Swelling**

**Bad Breath**

**Bleeding Gums**

**Chew Tobacco**

**Difficulty Chewing**

**Infection Of The Gums**

**Pain Around Ears**

**Sensitive Gums**

**Unusual Noises When You Eat**

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. If there are any changes in my health I will inform the doctor.

I authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs.

I give my consent to use local anesthetic.

I give my consent for the use of nitrous oxide gas if I have requested its use.

I authorize Hughes Dental Group to bill and receive payments from my insurance company.

I authorize Hughes Dental Group the use of this signature on all insurance submissions.

I authorize Hughes Dental Group to release all information necessary to secure the payment of benefits.

**I UNDERSTAND THAT I AM FULLY FINANCIALLY RESPONSIBLE FOR ALL CHARGES COVERED OR NOT COVERED BY MY INSURANCE COMPANY.**

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_