SCHOENING DDS

Health History Form

Today's Date

First Name	Last Name	Birth Date
Email	Home Phone	Cell Phone

Address	City	State	Zip

Height	Weight	Sex	Occupation

SS#	Emergency Contact	Phone #

Do you have any of the following diseases or problems?

Yes	No	DK		Yes	No	DK	
☐	☐	☐	Active Tuberculosis	☐	☐	☐	Cough that produces blood
☐	☐	☐	Persistant cough for over 3 weeks	☐	☐	☐	Been exposed to someone with tuberculosis

Dental Information

Yes	No	DK		Yes	No	DK	
☐	☐	☐	Do your gums bleeed when brushing/flossing?	☐	☐	☐	Do you have earaches or neck pain?
☐	☐	☐	Are your teeth sensitive to temperature/pressure?	☐	☐	☐	Do you have clicking/discomfort in jaw?
☐	☐	☐	Do you have dry mouth/Xerostomia?	☐	☐	☐	Do you brux or grind your teeth?
☐	☐	☐	Have you had periodontal (gum) treatments?	☐	☐	☐	Do you have sores/ulcers in your mouth?
☐	☐	☐	Have you have orthodontic treatment?	☐	☐	☐	Do you wear dentures/partials?
☐	☐	☐	Have you had problems from dental treatment?	☐	☐	☐	Do you participate in physical activity?
☐	☐	☐	Is your home water supply fluoridated?	☐	☐	☐	Have you had serious injury to mouth/head?
☐	☐	☐	Do you drink bottled/filtered water?	☐	☐	☐	Are you currently experiencing dental pain?

Date of last dental exam	What was done at that time?
Date of last dental x-rays	Reason for today's visit
How do you feel about your smile?	
Name of former dentist	Phone number

Medical Information

Primary Physician	Phone	Date of last exam
Address/City/State/Zip		
Preferred Pharmacy	Phone	
Address/City/State/Zip		

Yes	No	DK	
☐	☐	☐	Have you had a serious illness, operation, or been hospitalized in the past 5 years?

If yes, please explain

☐ ☐ ☐ Are you in good health?
☐ ☐ ☐ Has there been any change in your general health in the past year?
☐ ☐ ☐ Are you taking or have you recently taken any prescription/over the counter medicines?

If yes, please list

Yes No DK
☐ ☐ ☐ Do you use controlled substances (drugs)?
☐ ☐ ☐ Do you use any tobacco products?
☐ ☐ ☐ If you use tobacco, are you interested in quitting?
☐ ☐ ☐ Do you drink alcoholic beverages?

If yes, how much in the last 24 hours?

If yes, how much in an average week?

Women Only

Yes No DK
☐ ☐ ☐ Are you pregnant? How many weeks? _____
☐ ☐ ☐ Taking birth control / hormonal replacement?
☐ ☐ ☐ Nursing?

Yes No DK
☐ ☐ ☐ Have you had an orthopedictotal joint (hip, knee, elbow, finger) replacement?

Date?	Complications?

☐ ☐ ☐ Are you taking an antiresorptive agent for osteoporosis or Paget's disease?

☐ ☐ ☐ Since 2001 were you treated or are you presently scheduled to begin treatment with an antiresorptive agent for bone pain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer?

Date treatment began?

Allergies Are you allergic to or have you had a reaction to:

Yes No DK
☐ ☐ ☐ Local anesthetics
☐ ☐ ☐ Aspirin
☐ ☐ ☐ Penicillin or other antibiotics
☐ ☐ ☐ Barbiturates, sedatives, or sleeping pills
☐ ☐ ☐ Sulfa drugs
☐ ☐ ☐ Codeine or other narcotics

Yes No DK
☐ ☐ ☐ Metals
☐ ☐ ☐ Latex (rubber)
☐ ☐ ☐ Iodine
☐ ☐ ☐ Hay fever / seasonal
☐ ☐ ☐ Animals
☐ ☐ ☐ Food

List other allergies:

Have you had any of the following diseases or problems?

Yes No DK
☐ ☐ ☐ Artificial heart valve
☐ ☐ ☐ Past ineffective endocarditis
☐ ☐ ☐ Damaged transplanted heart
☐ ☐ ☐ Congenital heart disease
☐ ☐ ☐ Cardiovascular disease
☐ ☐ ☐ Angina
☐ ☐ ☐ Arteriosclerosis
☐ ☐ ☐ Congestive heart failure
☐ ☐ ☐ Damaged heart valves
☐ ☐ ☐ Heart attack
☐ ☐ ☐ Heart murmur
☐ ☐ ☐ Other heart defects
☐ ☐ ☐ Eating disorder
☐ ☐ ☐ Malnutrition
☐ ☐ ☐ Gastrointestinal disease
☐ ☐ ☐ GE Reflux / heartburn
☐ ☐ ☐ Ulcers
☐ ☐ ☐ Thyroid problems

Yes No DK
☐ ☐ ☐ Low blood pressure
☐ ☐ ☐ High blood pressure
☐ ☐ ☐ Mitral valve prolapse
☐ ☐ ☐ Pacemaker
☐ ☐ ☐ Rheumatic fever
☐ ☐ ☐ Rheumatic heart disease
☐ ☐ ☐ Abnormal bleeding
☐ ☐ ☐ Anemia
☐ ☐ ☐ Blood transfusion
If yes, date: _____
☐ ☐ ☐ Hemophilia
☐ ☐ ☐ AIDS or HIV infection
☐ ☐ ☐ Stroke
☐ ☐ ☐ Glaucoma
☐ ☐ ☐ Hepatitis / jaundice
☐ ☐ ☐ Liver disease
☐ ☐ ☐ Epilepsy
☐ ☐ ☐ Fainting spells / seizures

Yes No DK
☐ ☐ ☐ Arthritis
☐ ☐ ☐ Autoimmune disease
☐ ☐ ☐ Rheumatoid arthritis
☐ ☐ ☐ Systematic lupus
☐ ☐ ☐ Asthma
☐ ☐ ☐ Bronchitis
☐ ☐ ☐ Emphysema
☐ ☐ ☐ Sinus trouble
☐ ☐ ☐ Cancer/Chemo/Radiation
☐ ☐ ☐ Chest pain on exertion
☐ ☐ ☐ Chronic pain
☐ ☐ ☐ Diabetes Type I or II
☐ ☐ ☐ Neurological disorders
If yes, specify: _____
☐ ☐ ☐ Mental health disorders
If yes, specify: _____
☐ ☐ ☐ Sleep disorder
☐ ☐ ☐ Do you snore?

☐ ☐ ☐ Kidney problems
☐ ☐ ☐ Osteoporosis
☐ ☐ ☐ Swollen glands in neck
☐ ☐ ☐ Migraines / headaches

☐ ☐ ☐ Severe / rapid weight loss
☐ ☐ ☐ Sexually transmitted disease
☐ ☐ ☐ Excessive urination

☐ ☐ ☐ Night sweats
☐ ☐ ☐ Recurrent infections
☐ ☐ ☐ Cold sores / fever blisters

List any conditions not mentioned above:

Yes No DK

☐ ☐ ☐ Has a physician / previous dentist recommended that you take antibiotics prior to dental treatment?

Name of physician making recommendation:	Phone

Referral Information

Who should we thank for referring you to our office?

☐ Another patient, friend
☐ Another patient, relative
☐ Dental Office
☐ Internet Search
☐ Magazine
☐ Other

Name of person or office who referred you:

Spouse or Responsible Party Information

The following information is for ☐ The person responsible for payment ☐ The patient's spouse

First Name	Last Name	Birth Date
Phone	SS#	
Address	City	State/Zip

Employment Information

The following information is for ☐ The patient ☐ The person responsible for payment

Employer Name	Occupation	
Address of Employer	City	State/Zip

Insurance Information

Full Name of Insured	DOB of Insured
ID Number	Group Number
Address of Insured	City	State/Zip
Insured's Employer Name		
Address of Employer	City	State/Zip
Insurance Plan Name and Address		

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

NOTE: Both doctor and patient are encouraged to discuss any and all patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of patient / legal guardian: _____ Date: _____

Signature of dentist: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____