Dry Creek Dental
Health History Form

Patient Name: _____ Date: _____

Although dental personnel treat the area in and around your mouth, your mouth is the gateway to your body. Health problems that you might have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive.
Please answer the following questions below.

*Are you under a physician's care now? ◌ Yes ◌ No
If yes, list office/physician_____

*Have you ever been hospitalized or had a major operation? ◌ Yes ◌ No
If yes, list including date(s) _____
_____

*Have you ever had a serious head or neck injury? ◌ Yes ◌ No
If yes, list including date(s) _____
_____

*Are you taking any medications, supplements or vitamins? ◌ Yes ◌ No
If yes, please list _____
_____
_____
_____
_____

*Is antibiotic pre-medication required prior to your dental services? ◌ Yes ◌ No
(This is if you have had any joint replacements and your doctor requires you to pre-medicate)

*Have you ever taken any medications containing bisphosphonates? (Bone density) ◌ Yes ◌ No
If yes, what medication(s) have you taken/are taking, the history of medication(s) and frequency?
_____
_____

*Do you habitually clench/grind your teeth during the day or night? ◌ Yes ◌ No
*Do you wear a night guard? ◌ Yes ◌ No

*Do you use tobacco? ◌ Yes ◌ No

*Do you use controlled substances? ◌ Yes ◌ No
If yes, please list _____

WOMEN: Are you…
☐ Pregnant ☐Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives
If pregnant, how far along_____

*Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics
☐ Benzocaine ☐ Epinephrine Sensitive
☐ Other If yes, please list _____

Food Allergies? ◌ Yes ◌ No If yes, please list _____

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

AIDS/HIV Positive	◌ Yes ◌ No	Trouble Healing	◌ Yes ◌ No
*Viral Load_____		Hemophilia	◌ Yes ◌ No
Diabetes	◌ Yes ◌ No	Hepatitis A/B/C	◌ Yes ◌ No
*Most recent A1C_____		Anemia	◌ yes ◌ No
Renal Dialysis	◌ Yes ◌ No	Arthritis/Gout	◌ Yes ◌ No
High Blood Pressure	◌ Yes ◌ No	Artificial Heart Valve	◌ Yes ◌ No
Scarlet Fever	◌ Yes ◌ No	Artificial Joint	◌ Yes ◌ No
Shingles	◌ Yes ◌ No	Asthma	◌ Yes ◌ No
Sickle Cell Disease	◌ Yes ◌ No	Blood Disease	◌ Yes ◌ No
Sinus Trouble	◌ Yes ◌ No	Blood Transfusion	◌ Yes ◌ No
Spina Bifida	◌ Yes ◌ No	Breathing Problems/Easily Winded	◌ Yes ◌ No
Stomach Issues/Intestinal Disease	◌ Yes ◌ No	Bruise Easily	◌ Yes ◌ No
Stroke	◌ Yes ◌ No	Glaucoma/Eye Disease	◌ Yes ◌ No
Cancer	◌ Yes ◌ No	Hay Fever	◌ Yes ◌ No
Chemotherapy	◌ Yes ◌ No	Tuberculosis	◌ Yes ◌ No
Osteoporosis	◌ Yes ◌ No	Tumors or Growths	◌ Yes ◌ No
Pain in Jaw Joints	◌ Yes ◌ No	Ulcers	◌ Yes ◌ No
Parathyroid Disease	◌ Yes ◌ No	Vape/Tobacco Use	◌ Yes ◌ No
Acid Reflux/GERD	◌ Yes ◌ No	Dental Implants/Partials/Dentures	◌ Yes ◌ No
Depression/Anxiety	◌ Yes ◌ No	Attention Deficit ADD/ADHD	◌ Yes ◌ No
Radiation Treatments	◌ Yes ◌ No	Alzheimer's Disease	◌ Yes ◌ No
Anaphylaxis	◌ Yes ◌ No	Drug Addiction/Alcoholism	◌ Yes ◌ No
Angina/Chest Pain	◌ Yes ◌ No	Emphysema	◌ Yes ◌ No
Epilepsy or Seizures	◌ Yes ◌ No	High Cholesterol	◌ Yes ◌ No
Excessive Bleeding	◌ Yes ◌ No	Hives or Rash	◌ Yes ◌ No
Excessive Thirst	◌ Yes ◌ No	Hypoglycemia	◌ Yes ◌ No
Fainting Spells/Dizziness	◌ Yes ◌ No	Irregular Heartbeat/A-fibrillation	◌ Yes ◌ No
Frequent Cough	◌ Yes ◌ No	Kidney Problems	◌ Yes ◌ No
Frequent Diarrhea	◌ Yes ◌ No	Leukemia	◌ Yes ◌ No
Frequent Headaches	◌ Yes ◌ No	Liver Disease	◌ Yes ◌ No
Low Blood Pressure	◌ Yes ◌ No	Swelling of Limbs	◌ Yes ◌ No
Lung Disease	◌ Yes ◌ No	Thyroid Disease	◌ Yes ◌ No
Mitral Valve Prolapse	◌ Yes ◌ No	Heart Attack/Heart Failure	◌ Yes ◌ No
Cold Sores/Fever Blisters	◌ Yes ◌ No	Heart Murmur	◌ Yes ◌ No
Heart Disorder/Disease/Trouble	◌ Yes ◌ No	Heart Pacemaker	◌ Yes ◌ No
Heart Surgery	◌ Yes ◌ No	Blood Thinner	◌ Yes ◌ No
		*Most recent INR_____	
Mental Disability	◌ Yes ◌ No	Bisphosphonates	◌ Yes ◌ No
Sleep Apnea	◌ Yes ◌ No	Eczema/Psoriasis	◌ Yes ◌ No
Hearing Aids	◌ Yes ◌ No	Vertigo	◌ Yes ◌ No

Other serious illnesses not listed? ◌ Yes ◌ No
If yes, please list_____

Emergency Contact:
Name _____ Relation_____
Contact Number_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian

_____ Date_____