ANDERSON LAKE DENTAL HEALTH HISTORY FORM

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name:_____ Date_____

If you are completing this form for another person, what is your relationship to that person?
(Name)_____ (Relationship)_____

Do you have any of the following diseases or problems: (Check DK if you Don't Know the answer to the question)	Y	N	DK
Active Tuberculosis	Y	N	DK
Persistent cough greater than a 3 week duration	Y	N	DK
Cough that produces blood	Y	N	DK
Been exposed to anyone with tuberculosis	Y	N	DK

DENTAL INFORMATION

Do your gums bleed when you brush or floss	Y	N	DK
Are your teeth sensitive to cold, hot, pressure	Y	N	DK
Does food or floss catch between your teeth	Y	N	DK
Is your mouth dry	Y	N	DK
Have you had any periodontal (gum) treatments	Y	N	DK
Have you ever had orthodontic (braces) treatment	Y	N	DK
Have you had any problems associated with previous dental treatment	Y	N	DK
Do you drink bottle or filtered water	Y	N	DK
Are you currently experiencing pain/discomfort	Y	N	DK

Do you have earaches or neck pains	Y	N	DK
Do you have any discomfort in the jaw	Y	N	DK
Do you brux or grind your teeth	Y	N	DK
Do you have sores or ulcers in your mouth	Y	N	DK
Do you wear dentures or partials	Y	N	DK
Do you participate in active activities	Y	N	DK
Have you had a serious head or mouth injury	Y	N	DK

Date of your last dental exam_____
Date of last dental x-rays_____

What is the reason for your dental visit today?_____ How do you feel about your smile?_____

MEDICAL INFORMATION

Are you now under the care of a physician	Y	N	DK
Physician Name_____			
Phone _____			
Are you in good health	Y	N	DK
Has there been any change in your general health within the past year?	Y	N	DK
If yes, what condition is being treated_____			
Date of last physical exam_____			

Have you had a serious illness, operation or been hospitalized in the past 5 years	Y	N	DK
If yes, what was the illness or problem_____			
Are you taking or have you recently taken any prescription or over the counter medicines	Y	N	DK
If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:_____			
_____			

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	Y	N	DK
Scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma, metastatic cancer,	Y	N	DK
Date treatment began_____			

Do you use tobacco (smoking, snuff, chew, bidis)	Y	N	DK
WOMEN ONLY, are you:			
Pregnant?	Y	N	DK
Number of weeks:			
Taking birth control pills or hormonal replacement	Y	N	DK
Nursing	Y	N	DK