

Health History Form

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Mission Viejo, CA 92691



1 (949) 455-9480
<https://dentist4u.com/>

Email: _____ Today's Date: _____

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: Last First Middle			Primary Phone: Include area code ()		Secondary Phone: Include area code ()	
Address: Mailing address			City:		State: Zip:	
Occupation:			Height:		Weight: Date of Birth: Sex: M F	
Social Security #:		Emergency Contact Full Name:		Relationship:		Primary Phone: Include area code () Email
If you are completing this form for another person, what is your relationship to that person?						
Your Name			Relationship			
How did you hear about our practice? <input type="checkbox"/> Friend or Referral Name: _____ <input type="checkbox"/> Website <input type="checkbox"/> Online <input type="checkbox"/> Social Media <input type="checkbox"/> Advertisement <input type="checkbox"/> Flyer <input type="checkbox"/> Other _____			What is the reason for your dental visit today? How do you feel about your smile? Are you currently experiencing dental pain or discomfort?			

Dental Information

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do your gums bleed when you brush or floss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of your last dental exam:			
What was done at that time?			
Date of last dental x-rays:			

Medical Information

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Are you now under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician Name:			Phone: Include area code ()
Address/City/State/Zip:			
Date of last physical exam:			
Do you have any health conditions currently being treated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what condition(s) is/are being treated?			
Are you taking or have you recently taken any prescription or over the counter medicine(s) or supplement(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:			

Medical Information

Please checkmark your response to indicate if you have or have not had any of the following.

	Yes	No	DK		Yes	No	DK		Yes	No	DK	
Cardiovascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	WOMEN ONLY Are you: Pregnant? <input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Gastrointestinal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type of infection: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G.E. Reflux/persistent heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Damaged heart valves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus erythematosus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Low/High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice or liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Any other congenital heart defects: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					AIDS or HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

NOTE: Both doctor and patient are encouraged to discuss any and all relevant 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 his/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 his/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: _____

