neighborcare health

DENTAL HEALTH HISTORY QUESTIONNAIRE

Please Print

PATIENT'S LAST (FAMILY) NAME	FIRST NAME	MIDDLE INITIAL	☐ MALE ☐ FEMALE	TODAYS DATE MONTH DAY YEAR

PATIENT'S AGE	PATIENT'S BIRTHDATE MONTH DAY YEAR	NAME OF PERSON FILLING OUT THIS FORM IF OTHER THAN PATIENT	RELATIONSHIP TO PATIENT

NAME OF PATIENT'S PHYSICIAN	PHYSICIAN'S PHONE NUMBER	APPROXIMATE DATE OF LAST VISIT TO: PHYSICIAN MONTH DAY YEAR	DENTIST MONTH DAY YEAR

DIRECTIONS TO PATIENTS: Answers to these questions will help the dentist decide how to treat your dental problem. Try to circle each answer YES or NO. If you cannot answer a question, do not circle an answer.
Your answers will be considered strictly confidential.

1. What is the reason for your visit today? ______________________
2. Have you ever had any unusual reactions or complications related to any dental treatment? YES NO

   If yes, please explain: ______________________
3. Are you allergic or have you had a reaction to the following?
   - Latex .... YES NO
   - Penicillin or other antibiotics....... YES NO
   - Aspirin, Ibuprofen or Tylenol ...... YES NO
   - Local anesthetics .... YES NO

1. Are you currently seeing a doctor? YES NO

   If yes, please explain: ______________________
2. Have you ever had a serious illness, operation, or been hospitalized? YES NO

   If yes, please explain: ______________________
3. Are you taking any medications, pills, or over the counter medicines at this time? YES NO

   If yes, please list: ______________________

   ____

   ____
4. Do you have allergies to any other medications? YES NO

   If yes, please list: ______________________
5. Do you now have or have you had any of the following conditions?

Heart Problems	YES	NO	High Blood Pressure	YES	NO	Anemia	YES	NO	Psychiatric Care	YES	NO
Heart Murmur	YES	NO	Pacemaker	YES	NO	Bleeding Problems	YES	NO	ADD/ADHD	YES	NO
Chest Pains	YES	NO	Stroke	YES	NO	Arthritis	YES	NO	Autism	YES	NO
Artificial Joints/Valves	YES	NO	Arterial Grafts	YES	NO	Tumor/Cancer	YES	NO	TB/Tuberculosis	YES	NO
Diabetes	YES	NO	Kidney Problems	YES	NO	Thyroid Problems	YES	NO	AIDS/HIV Positive	YES	NO
Radiation Therapy	YES	NO	Undergoing Dialysis	YES	NO	Lung Disease	YES	NO	Hepatitis/Jaundice	YES	NO
Osteoporosis	YES	NO	Rheumatic Fever	YES	NO	Asthma	YES	NO	Herpes	YES	NO
Transplant (Bone/Organ)	YES	NO	Seizure Disorder/Epilepsy	YES	NO	Tobacco Use	YES	NO	Alcoholism/Drug Abuse	YES	NO

6. Women:

   Are you pregnant?.. YES NO

   Are you nursing at this time? .... YES NO

   Are you taking oral contraceptives? .... YES NO

   Are you taking hormone supplements? .... YES NO

I have filled out this health history to the best of my knowledge and agree to inform Neighborcare Health of any changes in my medical or dental health at the beginning of each dental appointment.

______________________ Patient or Guardian Signature

______________________ Today's Date