

## Patient Health History/Information Form

Please take your time filling out this form. Your health is extremely important to us. If there is anything that we did not ask you, please let us know!

Name \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

Marital Status \_\_\_\_\_ Social Security # \_\_\_\_\_ Driver's License# \_\_\_\_\_

Home Phone Number \_\_\_\_\_ Work Phone Number \_\_\_\_\_

Cell Phone Number \_\_\_\_\_

Occupation \_\_\_\_\_ Employer Name/Information \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Emergency Contact Phone#/Address \_\_\_\_\_

Primary Insurance Carrier \_\_\_\_\_ Policy/Grp# \_\_\_\_\_

Insurance Carrier Address \_\_\_\_\_

Insurance Phone # \_\_\_\_\_

Employee Name \_\_\_\_\_ Employer \_\_\_\_\_

Employee Social Security # \_\_\_\_\_

Physician Name/Address \_\_\_\_\_

Please list the reason for your dental visit (your chief complaint) \_\_\_\_\_

Please circle **yes/no** if you have or had any of the following conditions:

Hypertension/High Blood Pressure	Yes	No	Thyroid problems	Yes	No
Heart Disease	Yes	No	Asthma	Yes	No
Heart Murmur	Yes	No	Bronchitis/Emphysema	Yes	No
Heart Attack	Yes	No	Tuberculosis	Yes	No
Stroke	Yes	No	Kidney Disease	Yes	No
Chest Pain/Angina	Yes	No	Mental Health	Yes	No
Pace Maker	Yes	No	Sexually Transmitted Disease	Yes	No
Diabetes	Yes	No	Headaches	Yes	No
Arthritis/Joint Pain	Yes	No	HIV/AIDS	Yes	No
GERD/ Acid Reflux	Yes	No	Seasonal Allergies/ Hay Fever	Yes	No
Epilepsy/Seizures	Yes	No	Muscle Pain	Yes	No
Cancer	Yes	No	Stomach/Intestinal Problems	Yes	No
Hepatitis, Jaundice, Liver Disease	Yes	No	Substance Abuse	Yes	No
Anemia/ Sickle Cell	Yes	No	Immune Compromised	Yes	No
Bleeding Disorder	Yes	No	Allergy to Latex	Yes	No

**Women:** Are you pregnant? Yes No      Are you nursing? Yes No

Are you taking birth control pills? Yes No

Medications(name and doses)	Allergies	Hospitalizations	Surgeries


Do you have any diseases or conditions not listed above? If so, please list. \_\_\_\_\_

Have you ever taken Phen-fen? \_\_\_\_\_

Do you have a history of substance abuse? \_\_\_\_\_

Have you have taken or been given injections of steroids or corticosteroids?  
 Yes No If yes, please list the reason and date \_\_\_\_\_

We appreciate the expression of confidence when our patients refer their friends to our office! Who may we thank for referring you to our office? \_\_\_\_\_

I certify that the following information is filled out completely and filled out to the best of my knowledge.

\_\_\_\_\_  
 (signature)

\_\_\_\_\_  
 To be filled out by doctor

**HPI**

Significant Diseases \_\_\_\_\_

Allergies \_\_\_\_\_

Hospitalization/surgeries \_\_\_\_\_

Allergies \_\_\_\_\_

**ROS**

Cardiac: Chest Pain( ) Chest tightness( ) Rapid Heartbeat ( ) Irregular Heartbeat( ) \_\_\_\_\_

HEENT: diploplea( ) blurry vision( ) sore throat( ) tinnitus( ) \_\_\_\_\_

Pulmonary: Shortness of breath ( ) Wheezing( ) Coughing( ) \_\_\_\_\_

Neuro: Dizziness( ) Numbness ( ) Tingling of Extremities( ) Headaches( ) Vertigo( ) \_\_\_\_\_

Endocrine: Hot Intol( ) Cold Intol( ) Polyurea ( ) Polydypsea ( ) Polyphagia ( ) \_\_\_\_\_

GI: Ulcers ( ) Constipation ( ) Diarrhea( ) Nausea/Vomiting ( ) \_\_\_\_\_

**Family History:** Any known genetic diseases that run in your family? \_\_\_\_\_

**Social History:** Tobacco Use - \_\_\_\_\_ Alcohol Use- \_\_\_\_\_

Recreational Drug Use- \_\_\_\_\_