Westborough Dental Associates **Health History** **PT. ID#_____**

_____ _____ _____

Patient Name (Please Print) DOB DATE

Medical issues or medications could have an important interrelationship with the dentistry that you may be receiving. Please complete thoroughly:

Physician's Name: _____ Phone #: _____ Last Exam: _____

Are you under physician's care now? ○ Yes ○ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes, please list all: _____

Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No _____

Have you ever taken Fosamax, Boniva, Acotnel or any other medications containing bisphosphonates? ○ Yes ○ No _____

Are you on a special diet? ○ Yes ○ No

Do you use tobacco? ○ Yes ○ No

Do you use controlled substances? ○ Yes ○ No

List any non-prescription or over the counter products you're taking: _____

Women only:

Pregnant/Trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Allergies: (Please mark "No" if you have not had an allergic reaction or have not previously been exposed to the following)

Aspirin ○ Yes ○ No	Iodine ○ Yes ○ No	Metals ○ Yes ○ No	Sulfa Drugs ○ Yes ○ No
Barbiturates ○ Yes ○ No	Latex ○ Yes ○ No	Penicillin ○ Yes ○ No	Others: ○ Yes ○ No
Codeine ○ Yes ○ No	Local Anesthetics ○ Yes ○ No	Sedatives ○ Yes ○ No	_____

Health Conditions/Concerns:

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

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problem ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
			Yellow Jaundice ○ Yes ○ No

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes, please explain: _____

Dental History/Concerns:

Gums bleed while brushing or flossing ○ Yes ○ No	Previous orthodontic treatment ○ Yes ○ No	Tooth sensitivity to hot or cold ○ Yes ○ No
Tooth pain ○ Yes ○ No	Is Fluoride taken in any form ○ Yes ○ No	Tooth sensitivity to sweet or sour ○ Yes ○ No
Sores or lumps in or out of mouth ○ Yes ○ No	Mouth habits: nail biting, thumb sucking ○ Yes ○ No	Clenching or grinding teeth ○ Yes ○ No
Previous difficult extractions ○ Yes ○ No	Biting lips or cheeks frequently ○ Yes ○ No	Difficulty with chewing ○ Yes ○ No
Any prolonged bleeding after extraction ○ Yes ○ No	Do you use an electric toothbrush ○ Yes ○ No	Is there anything you would like to change about your smile? _____
How often do you brush your teeth? _____	How often do you floss? _____	

Acknowledgement:

Office Use Only: ♥ Blood Pressure: / **Pre-Med Status: ○ Yes ○ No**

To the best of my knowledge, the above questionnaire has been answered accurately. I understand that providing incorrect information can be dangerous to my (or the patients) health. I also understand that it is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Signature of Patient/Guardian **Date**

_____ _____

Signature of Dentist **Date**