DUXBURY DENTAL ASSOCIATES HEALTH HISTORY FORM

Name: _____ **Nickname:** _____
Address:_____
_____
Telephone: Preferred #1: _____ **#2:** _____
DOB: _____ **Email Address:** _____
Emergency Contact: _____ Tel #: _____

Do you have or have you ever had: (Please circle all that apply.)

Kidney Issues	Yes	No	Hepatitis/Liver Issues	Yes	No
Thyroid Issues	Yes	No	High/Low Blood Pressure	Yes	No
Stroke	Yes	No	Pacemaker	Yes	No
Respiratory Issue/Asthma	Yes	No	Cardiac Stent/Valve Placed	Yes	No
Artificial Joints	Yes	No	Mitral Valve Prolapse	Yes	No
Back Issues	Yes	No	Diabetes	Yes	No
Ulcer/Colitis	Yes	No	Chemical Dependency	Yes	No
Rheumatic/Scarlet Fever	Yes	No	Mental Health Issues	Yes	No
Blood Disorders	Yes	No	Cancer and/or Treatment	Yes	No
Epilepsy/Fainting	Yes	No	STD / HIV / AIDS	Yes	No
Heart Disease	Yes	No	Autoimmune Disease	Yes	No

Other _____

Major Surgeries or Illnesses: _____

Current Medications:	**Known Drug/Material Allergies:**

Do you smoke? Yes No Chew tobacco? Yes No

Are you currently being treated by a Specialist? Yes No May we contact them? Yes No
Name of Specialist: _____ Tel #: _____

Have you been prescribed an antibiotic to take prior to dental treatment? Yes No

Please circle if you are having any of the following problems:

Bad Breath	Food Collecting Between Teeth	Growths In Mouth	Loose Teeth
Bleeding Gums	Grinding/Clenching Teeth	Broken Fillings	Clicking/Popping Jaw
Bad Taste	Sensitivity to Hot/Cold/Sweets	Difficulty Chewing	Dry Mouth

If you could make any changes to your smile, what would it be?_____

Signature: _____ Date: _____

FOR OFFICE USE ONLY:

Date: _____ Hygienist: _____

Has patient seen their Medical Provider since we last treated them? Yes No

NOTES: _____
_____
_____

Date: _____ Hygienist: _____

Has patient seen their Medical Provider since we last treated them? Yes No

NOTES: _____
_____
_____

Date: _____ Hygienist: _____

Has patient seen their Medical Provider since we last treated them? Yes No

NOTES: _____
_____
_____

Date: _____ Hygienist: _____

Has patient seen their Medical Provider since we last treated them? Yes No

NOTES: _____
_____
_____

Date: _____ Hygienist: _____

Has patient seen their Medical Provider since we last treated them? Yes No

NOTES: _____
_____
_____