ALPINE DENTISTRY

1620 ALPINE BLVD., SUITE 121, ALPINE, CA 91901
ALPINEDENTISTRY.COM

HEALTH HISTORY FORM

Patient Name_____ Email Address_____

CIRCLE APPROPRIATE ANSWER (leave blank if you do not understand question) PLEASE COMPLETE BOTH COLUMNS

Yes	No	Is your general health good?
Yes	No	Has there been a change in your health within the last year?
Yes	No	Have you been hospitalized or had a serious illness in the last three years?
		If YES, explain_____
Yes	No	Are you being treated by a physician now? For what?_____
		Date of last Medical exam: _____Date of last Dental Exam _____
Yes	No	Have you had problems with prior dental treatment, Explain:_____
Yes	No	Are you in pain now? Which area?_____
Yes	No	Do you require antibiotics before dental treatment?_____
Yes	No	Have you been vaccinated for COVID-19?

HAVE YOU EXPERIENCED:

Yes	No	Chest pain (angina)	Yes	No	Dizziness
Yes	No	Swollen ankles	Yes	No	Ringing in ears
Yes	No	Shortness of breath	Yes	No	Seizures
Yes	No	Recent weight loss, fever, night sweats	Yes	No	Allergy to Aspirin
Yes	No	Persistent cough, coughing up blood	Yes	No	Allergy to Codeine
Yes	No	Bleeding problems, bruising easily	Yes	No	Allergy to Dental Anesthetics
Yes	No	Sinus problems	Yes	No	Allergy to Erythromycin
Yes	No	Difficulty swallowing	Yes	No	Allergy to Latex
Yes	No	Headaches, jaw pain	Yes	No	Allergy to Penicillin
Yes	No	Dry mouth	Yes	No	Allergy to Sulfa drugs
Yes	No	Fainting spells (next column)	Yes	No	Allergy to Tetracycline

DO YOU HAVE OR HAVE YOU HAD:

Yes	No	Heart Disease	Yes	No	AIDS
Yes	No	Heart attack, heart defects	Yes	No	Tumors, cancer
Yes	No	Heart murmur/Mitral valve prolapse	Yes	No	Radiation, chemotherapy
Yes	No	Rheumatic fever	Yes	No	Anemia
Yes	No	Pacemaker/ Prosthetic Heart Valve	Yes	No	Cold Sores
Yes	No	Artificial joint/Date placed_____	Yes	No	Thyroid problems
Yes	No	High blood pressure	Yes	No	Diabetes
Yes	No	Blood transfusions	Yes	No	Lupus
Yes	No	Asthma, TB, emphysema, other lung disease	Yes	No	Hepatitis , other liver disease
Yes	No	Stroke (next column)	Yes	No	Arthritis, Rheumatism

DO YOU USE:

Yes	No	Tobacco in any form	Yes	No	Drugs, medications, over-the-counter medicines
Yes	No	Alcohol			(including Aspirin), natural remedies

Please list all current medications_____

_____

Yes No Do you have or had any other diseases or medical problems NOT listed on this form, If so, please explain:

_____

Yes No Do you have any other allergies NOT listed on this form?_____

Yes	No	Do you floss daily?	Yes	No	Do your gums ever bleed?
Yes	No	Have you ever had periodontal disease?	Yes	No	Do you have loose teeth?
Yes	No	Do you have crowded teeth?	Yes	No	Would you like straighter teeth?
Yes	No	Do you feel you have a snoring problem?	Yes	No	Do you have Sleep Apnea?

WOMEN ONLY

Yes	No	Are you or could you be pregnant?	Yes	No	Are you nursing?

To the best of my knowledge, I have answered every question completely and accurately. I will inform the dentist of any change in my health and/or medications.

1. Patient/Parent Signature_____Date_____
2. Patient/Parent Signature_____Date_____
3. Patient/Parent Signature_____Date_____

Dr. Signature_____