

# Confidential Health History Form

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Encinitas, CA

Today's Date \_\_\_\_\_

Patient Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ Date of Birth \_\_\_\_\_

### I. Circle appropriate answer (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?  
If NO, explain \_\_\_\_\_
2. Yes / No Has there been a change in your health within the last year?  
If YES, explain \_\_\_\_\_
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?  
If YES, explain \_\_\_\_\_
4. Yes / No Are you being treated by a physician now?  
If YES, explain \_\_\_\_\_  
Date of last medical exam? \_\_\_\_\_ Reason for exam \_\_\_\_\_
5. Yes / No Have you had problems with prior dental treatment?  
If YES, explain \_\_\_\_\_  
Date of last dental exam \_\_\_\_\_ Name of last treating dentist \_\_\_\_\_
6. Yes / No Do you have reservations against particular dental treatment?  
If YES, how so? \_\_\_\_\_

### II. Have you experienced any of the following? (Please circle Yes or No for each)

- |   |                                   |                                  |
|---|-----------------------------------|----------------------------------|
| Yes / No Chest pain (angina)            | Yes / No Blood in stools          | Yes / No Frequent vomiting       |
| Yes / No Fainting spells                | Yes / No Diarrhea or constipation | Yes / No Jaundice                |
| Yes / No Recent significant weight loss | Yes / No Frequent urination       | Yes / No Dry mouth               |
| Yes / No Fever                          | Yes / No Difficulty urinating     | Yes / No Excessive thirst        |
| Yes / No Night sweats                   | Yes / No Ringing in ears          | Yes / No Difficulty swallowing   |
| Yes / No Persistent cough               | Yes / No Headaches                | Yes / No Swollen ankles          |
| Yes / No Coughing up blood              | Yes / No Dizziness                | Yes / No Joint pain or stiffness |
| Yes / No Bleeding problems              | Yes / No Blurred vision           | Yes / No Shortness of breath     |
| Yes / No Blood in urine                 | Yes / No Bruise easily            | Yes / No Sinus problems          |

### III. Have you had or do you have any of the following? (Please circle Yes or No for each)

- |  |  |                                     |
|--|--|-------------------------------------|
| Yes / No Heart disease                   | Yes / No Cosmetic surgery                | Yes / No Eating disorders           |
| Yes / No Family history of heart disease | Yes / No Surgeries                       | Yes / No Osteoporosis               |
| Yes / No Heart attack                    | Yes / No Hospitalization                 | Yes / No Thyroid disease            |
| Yes / No Artificial joint                | Yes / No Diabetes                        | Yes / No Asthma                     |
| Yes / No Stomach problems or ulcers      | Yes / No Family history of diabetes      | Yes / No Hepatitis                  |
| Yes / No Heart defects                   | Yes / No Tumors or cancer                | Yes / No Sexual transmitted disease |
| Yes / No Heart murmurs                   | Yes / No Chemotherapy                    | Yes / No Herpes                     |
| Yes / No Rheumatic fever                 | Yes / No Radiation                       | Yes / No Canker or cold sores       |
| Yes / No Skin disease                    | Yes / No Arthritis, rheumatism           | Yes / No Anemia                     |
| Yes / No Hardening of arteries           | Yes / No Emphysema or other lung disease | Yes / No Liver disease              |
| Yes / No High blood pressure             | Yes / No Kidney or bladder disease       | Yes / No Eye disease                |
| Yes / No Seizures                        | Yes / No Stroke                          | Yes / No Transplants                |
|  |  | Yes / No Tuberculosis               |

This information will not be released unless specifically authorized by patient.

Yes/No AIDS/HIV

Yes/No Anxiety

Yes/No Depression

Yes/No Treatment for emotional condition

### IV. Are you allergic to or have you had a reaction to any of the following? (Please circle Yes or No for each)

- |  |                       |                        |
|--|-----------------------|------------------------|
| Yes / No Aspirin                                     | Yes / No Valium       | Yes / No Tetracycline  |
| Yes / No Darvon                                      | Yes / No Demerol      | Yes / No Vicodin       |
| Yes / No Codeine                                     | Yes / No Penicillin   | Yes / No Percodan      |
| Yes / No Latex                                       | Yes / No Food         | Yes / No Nitrous oxide |
| Yes / No Local anesthetic<br>(Novocain or Xylocaine) | Yes / No Erythromycin | Yes / No Metal         |

Others \_\_\_\_\_



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## Dental Health Questionnaire

We believe that each patient deserves to know what their current level of dental health is, how they got there, and what treatment options are available to help them reach the level of health that they deserve. This begins with a careful diagnosis and personalized treatment plan. We will perform a comprehensive oral examination of your teeth, gums, jaw joints, bite and soft tissues. We will also take the appropriate x-rays, and when beneficial we may take additional diagnostic records such as photographs or casts of your teeth to further evaluate areas of concern.

Once all your records have been completed they will be carefully evaluated to determine your current level of dental health and how you got there. We will review our findings with you and discuss your treatment options. A personalized treatment plan will then be developed to help you achieve the goals we set together.

Please help us better understand your dental health needs and goals by answering the following questions.

(check the best answer):

1. Have you had a full mouth set of x-rays (other than routine cavity detecting x-rays) within the last 3 years?  Yes  No
2. I have a  low  moderate  high fear of going to the dentist.
3. My mouth and teeth are  very  moderately  not **comfortable**.
4. I am  very **satisfied**  **satisfied**  **dissatisfied** with the appearance of my teeth.
5. I think my present state of dental health is  excellent  good  fair  poor.
6. I would say that my main concerns with my dental health are: \_\_\_\_\_
7. I am interested in a smile evaluation and personalized treatment plan to enhance my smile.  Yes  No
8. Please check which statement below best represents the level of dental health you wish to achieve.  
(Some people begin at one level and progress to a higher level over time.)

**HEALTH LEVEL I - Emergency Care**

I am only interested in emergency dental care for the relief of pain and/or cosmetic embarrassment.

I am not very interested in thinking about the future of my teeth at this time.

**HEALTH LEVEL II - Maintenance Care**

I am interested in maintenance care by taking an active part in the prevention of the disease process and the repair of existing problems. However, I am not yet ready for a higher level of dental care due to limitations of time and/or money. I understand that maintenance care may not be enough to help me achieve maximum protection and longevity and that my dental health may not remain stable over time.

**HEALTH LEVEL III - Comprehensive Care**

I am interested in comprehensive care to achieve and maintain a higher level of dental health.

I am concerned about treating the causes of dental diseases, not simply the effects.

I want all dental treatment provided to be the best available for maximum protection and longevity, so as to achieve long-term stable dental health.

**HEALTH LEVEL IV - Comprehensive & Cosmetic Care**

I am interested in comprehensive and cosmetic care to achieve and maintain the highest level of dental health.

I am concerned about treating the causes of dental diseases, not simply the effects.

I want all dental treatment provided to be the best available in cosmetic dentistry for maximum protection, longevity, and esthetics, so as to achieve long-term stable, yet esthetic, dental health.