Confidential Health History Form

Gannon Lee, D.D.S. 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 (Novocain or Xylocaine)	Yes / No	Erythromycin	Yes / No	Metal

Others _____

V. Are you taking or have you taken any of the following in the last three months? (Please circle Yes or No for each)

Yes / No Recreational drugs
Yes / No Over-the-counter medicines
Yes / No Weight loss medications
Yes / No Cortico - Steroids

Yes / No Tobacco in any form
Yes / No Alcohol
Yes / No Bisphosphonate (Fosamax)

Yes / No Antibiotics
Yes / No Supplements
Yes / No Aspirin

Please list all medications you are currently taking _____

VI. Women only (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, what month? _____
Yes / No Are you nursing?
Yes / No Are you taking birth control pills?

VII. All patients (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If YES, explain _____

_____

Yes / No Have you ever been pre-medicated for dental treatment?

If YES, why _____

Yes / No Have you ever taken Fen-Phen?

If YES, when _____

Yes / No Is there any issue or condition that you would like to discuss with the dentist in private?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature _____ Date _____

Physician's Name _____ Phone Number _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian)	Date	Signature of Dentist	Date
_____	_____	_____	_____

Medical updates

I have reviewed my Health History and confirm that it accurately states past and present conditions.

Date	Patient Signature	Changes to Health History	Dentist Initials

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.