BOND
FAMILY DENTISTRY

Health History Form

Patient Name: _____ **Date of Birth**:_____

Physicians name, phone # and date of last exam:_____

List of medications:

_____

_____

List any allergies (Penicillin, Codeine, Latex, etc.) :

_____

_____

Have you been hospitalized? If so, please list dates and reasons: _____

_____

Do you have or have you ever had any of the following? Please circle Yes or No:

Yes No Artificial Joints	**Yes No** Kidney problems	**Yes No** Arthritis
Yes No High blood pressure	**Yes No** HIV/AIDS	**Yes No** Lupus
Yes No Arrhythmias	**Yes No** Ulcers	**Yes No** Anxiety
Yes No Heart Disease	**Yes No** Stomach problems	**Yes No** Depression
Yes No Heart Attack	**Yes No** Acid Reflux	**Yes No** Psychiatric care
Yes No Artificial Heart Valve	**Yes No** Pacemaker	**Yes No** Defibrillator
Yes No Bleeding Disorders	**Yes No** Prolonged Bleeding	**Yes No** Bone Disease
Yes No Angina	**Yes No** Osteoporosis	**Yes No** Dental anxiety
Yes No Anemia	**Yes No** Ear problems	**Yes No** Sleep Apnea
Yes No Leukemia	**Yes No** Asthma	**Yes No** TMJ pain
Yes No Blood dyscrasias	**Yes No** Thyroid	**Yes No** Tobacco use
Yes No Stroke	**Yes No** Adrenal Problems	**Yes No** Marijuana Use

Yes No Aneurysm **Yes No** Chemotherapy **Yes No** E-Cigarettes

Yes No Seizure **Yes No** Radiation Therapy **Yes No** Drug Abuse

Yes No Hepatitis **Yes No** Cancer **Yes No** Alcohol Abuse

Yes No Liver disease **Yes No** Tumors **Yes No** Pregnant

Yes No Sinus problems **Yes No** Lung disease **Yes No** Nursing

Yes No Tuberculosis **Yes No** Periodontal Gum Disease

Yes No Diabetes **Yes No** Family History of gum disease

Yes No Family History of Diabetes

Yes No Please list any other medical conditions: _____

_____

Yes No Would like to discuss sedation options for you dental treatment?

Rate your smile, with 10 being perfect: 1 2 3 4 5 6 7 8 9 10

When was your last dental cleaning? _____

Name and phone # of last dentist: _____

How often do you: Brush _____ **Floss your teeth** _____

To the best of my knowledge, I have filled out this Health History Form completely and accurately

Patient/Guardian Signature: _____ **Date:** _____

Hygienist/Assistant Signature: _____ **Date**: _____

Doctor Signature: _____ **Date**: _____