SEMO HEALTH NETWORK

Patient Name: ______________________
Date of Birth: ______ /______ /______ Today's Date: ____________

# HEALTH HISTORY FORM

Name of physician: ______________________ City: ______________________
Date of last exam: ____________ Reason: ______________________

**Please list any medications, over-the-counter drugs, or supplements you take:**

______________________________________________
______________________________________________
______________________________________________

**Please circle any allergies or adverse reactions:**

Amoxicillin/Penicillin Codeine Latex Local Anesthetic Iodine Metals Sulfa
Dental Materials Aspirin Other: ______________________

## General Health

| Please Check: | Yes | No | Don't Know |
|---|---|---|---|
| Are you in good health? | ❑ | ❑ | ❑ |
| Have there been any changes to your health in the last year? | ❑ | ❑ | ❑ |
| Have you had any serious illness, operation, or been hospitalized in the past five years? | ❑ | ❑ | ❑ |

If yes, describe: ______________________
______________________________________________

| Please Check: | Yes | No | Don't Know |
|---|---|---|---|
| Have you had a total joint replacement? | ❑ | ❑ | ❑ |

If yes, when? ____________
What joint? ______________________

| Please Check: | Yes | No | Don't Know |
|---|---|---|---|
| Has a doctor ever told you to take antibiotics before dental treatment? | ❑ | ❑ | ❑ |
| Have you ever taken IV bisphosphonates? | ❑ | ❑ | ❑ |

(Examples: Boniva, Fosamax, alendronate)

**Women Only:**

| | Yes | No | Don't Know |
|---|---|---|---|
| Are you or could you be pregnant? | ❑ | ❑ | ❑ |
| Are you breast-feeding? | ❑ | ❑ | ❑ |

## Review of Systems:

Please mark all that apply.

| Please Check: | Yes | No | Don't Know |
|---|---|---|---|
| Abnormal Bleeding | ❑ | ❑ | ❑ |
| AIDS or HIV Infection | ❑ | ❑ | ❑ |
| Anemia | ❑ | ❑ | ❑ |
| Arthritis | ❑ | ❑ | ❑ |

(circle) Osteoarthritis or Rheumatoid arthritis

| Please Check: | Yes | No | Don't Know |
|---|---|---|---|
| Blood Transfusion | ❑ | ❑ | ❑ |

If yes, date: ____________

| Please Check: | Yes | No | Don't Know |
|---|---|---|---|
| Cancer | ❑ | ❑ | ❑ |

## Review of Systems:

Please mark all that apply.

Cardiovascular disease:
If **yes,** specify below by marking with an **X**:

___ High blood pressure ___ Low blood pressure
___ Angina ___ Heart Murmur
___ Artificial heart valves ___ Heart attack
___ Mitral valve prolapse ___ Atherosclerosis
___ Rheumatic fever ___ Pacemaker
___ Arteriosclerosis ___ Irregular heart beat
___ Congestive heart failure

| Please Check: | Yes | No | Don't Know |
|---|---|---|---|
| Diabetes | ❑ | ❑ | ❑ |

Please specify: Type I ___ or Type II ___

| Please Check: | Yes | No | Don't Know |
|---|---|---|---|
| Eating Disorder | ❑ | ❑ | ❑ |
| Epilepsy/Seizures | ❑ | ❑ | ❑ |
| Glaucoma | ❑ | ❑ | ❑ |
| Hemophilia | ❑ | ❑ | ❑ |
| Hepatitis | ❑ | ❑ | ❑ |

Type (circle): A B C

| Please Check: | Yes | No | Don't Know |
|---|---|---|---|
| Kidney problems | ❑ | ❑ | ❑ |
| Neurologic disorders | ❑ | ❑ | ❑ |
| Organ transplant | ❑ | ❑ | ❑ |
| Osteoporosis/osteopenia | ❑ | ❑ | ❑ |
| Sinus trouble | ❑ | ❑ | ❑ |
| Sexual transmitted disease | ❑ | ❑ | ❑ |
| Steroid therapy | ❑ | ❑ | ❑ |
| Stroke | ❑ | ❑ | ❑ |
| Thyroid disease | ❑ | ❑ | ❑ |
| Tuberculosis | ❑ | ❑ | ❑ |
| Ulcers | ❑ | ❑ | ❑ |

Other condition not listed: ______________________

## Mental and Developmental Health

| Please Check: | Yes | No | Don't Know |
|---|---|---|---|
| Anxiety | ❑ | ❑ | ❑ |
| ADD/ADHD | ❑ | ❑ | ❑ |
| Autism | ❑ | ❑ | ❑ |
| Depression | ❑ | ❑ | ❑ |

If yes, site: ______________
Chemotherapy or radiation ❑ ❑ ❑

Mental, behavioral, developmental condition not specified: ____________________________________

Patient Name: ____________________________________________________________
Date of Birth: ________ /_________ /_________ Today's Date: ___________________

## DENTAL AND LIFESTYLE HISTORY FORM

**Lifestyle**
Do you have any physical or mental disabilities that may require special care such as hearing, sight, or speech impairments? If yes, please describe:
_____________________________________________________________________________
Do you drink alcohol? (Circle) Yes No
Please list amount and frequency: ______________________________________
Do you smoke or use tobacco? (Circle) Yes No
Please list type and amount: ___________________________________________
Do you use any street drugs? (Circle) Yes No
Please list type: _____________________________________________________________

**Dental History**
What is your reason for seeking care today?
_____________________________________________________________________________
_____________________________________________________________________________
Do you have regular dental check-ups? ❑ Yes ❑ No
Date of last dental exam: ____________________
Date of last dental x-rays: _________________________
Have you had any trouble with previous dental treatment? ❑ Yes (Explain below) ❑ No
_____________________________________________________________________________
_____________________________________________________________________________
How do you care for your teeth?
_____________________________________________________________________________

| | Yes | No | Don't Know |
|---|---|---|---|
| Has fear ever prevented you from seeking dental care? | ❑ | ❑ | ❑ |
| Do your gums bleed when you brush your teeth? | ❑ | ❑ | ❑ |
| Do you have lumps or sores in your mouth? | ❑ | ❑ | ❑ |
| Do you suffer from pain in the mouth, face, eyes, neck, or throat? | ❑ | ❑ | ❑ |
| Do you ever have pain, clicking, or popping in your jaw (TMJ)? | ❑ | ❑ | ❑ |
| Are you happy with the appearance of your teeth? | ❑ | ❑ | ❑ |
| Do you want to save your teeth? | ❑ | ❑ | ❑ |
| Do you feel that you have dry mouth? | ❑ | ❑ | ❑ |
| Do you eat or drink sugary foods or drinks? | ❑ | ❑ | ❑ |
| Have you ever injured your face, jaws, or teeth? | ❑ | ❑ | ❑ |

**Please check any dental treatment you have received in the past:**

| | | | |
|---|---|---|---|
| ❑ Fillings | ❑ Orthodontics (braces) | ❑ Oral Surgery (extractions) | ❑ Gum treatment |
| ❑ Root canals | ❑ Dentures | ❑ Implants | ❑ TMJ treatment |

Do you have any other concerns, conditions, or comments not addressed?
_____________________________________________________________________________ ____

**I affirm that this record is true and accurate to the best of my knowledge (Check: ❑ Self ❑ Parent/Guardian)**

X______________________________________________________________ ____________________________

Signature Date