VALLEY
Family Health Care
Healthy Families. Strong Communities.

DENTAL HEALTH HISTORY

Date: _____

Patient Name: _____ Date of Birth: _____

For **minors**, list names of all parents/guardians: _____

Date of last Dental Exam: _____ Dental Cleaning: _____ Physical Exam: _____

Pharmacy of choice: _____ Pharmacy phone number: _____

What is the **main reason** you are seeking dental treatment? _____

Please circle (Y)es or (N)o to the questions below

Y **N** 1. Have there been any **changes** in your **general health** within the last year?

Y **N** 2. Are you presently or have you been under the care of a **physician** during the last year?
Where do you seek medical attention?
List Medical Provider and clinic: _____

Y **N** 3. Have you had any serious **illnesses, operations, or hospitalizations** within the last 5 years?
Explain:_____

Y **N** 4. Are you **pregnant**? Due date: _____

Y **N** 5. Do you take **birth control** medication? **(Antibiotics can decrease the effectiveness of birth control medications).**

Y **N** 6. Have you ever taken, or do you currently take bisphosphonates **(medications given to treat osteoporosis or cancer, examples include Aredia, Boniva, Fosamax, Actonel, Zometa**)?

Y **N** 7. Have you ever or are your now taking **steroids**?

Y **N** 8. Are you currently taking blood thinners such as Warfarin (Coumadin) or Pradaxa?

Y **N** 9. Are you taking any **medication(s)** including non-prescription drugs? (Please list below.)

☐ I am not currently taking any medications.

LIST ALL MEDICATIONS AND/OR SUPPLEMENTS

_____
_____
_____
_____

Y **N** 10. Do you use or have you ever used **smoking** tobacco products? _____/day. Quit _____

Y **N** 11. Do you use or have you ever used **smokeless** tobacco products? _____/day. Quit _____

Y **N** 12. Do you or have you ever used **vape** smoking products? _____/day. Quit_____

Y **N** 13. Do you drink soda pop? How much _____. How often? (times) _____/day.

Y **N** 14. Do you drink alcohol or alcoholic beverages? How often? _____

Y **N** 15. Do you eat sugary foods such as candy more than four times per day?

Y **N** 16. Do you currently have pain discomfort, or sensitivity in your teeth or gums?

Y **N** 17. Are you **nervous** about dental treatment?

Y **N** 18. Do your **gums bleed** while brushing or flossing?

Y **N** 19. Do you have **dry mouth**?

Y N 20. Are you allergic or have you **EVER** had a reaction (swelling, rash, itching) to any of the following? (Circle all that apply)

Penicillin **Latex/rubber products** **Metals/Jewelry**
Pain Medications
Other antibiotics _____ **Local anesthetics (numbing agents)**
Other: _____

Y N **21.** Do you have or have you ever had a problem with alcohol or drugs? **(All information is kept confidential.)**

***Beware that alcohol or drug use may cause adverse effects when combined with anesthetics, nitrous oxide, or other dental agents**

Y N 22. Have you ever had any of the following? (Circle all that apply)

Prosthetic heart valve **Congenital heart disease** **Total joint replacement**
Infective endocarditis (heart infection) **Heart transplant**

Do you have or have you ever had any of the following? (Circle all that apply)

Heart trouble/Surgery	ADD or ADHD	Stomach ulcers
Chest pain	Autism	Acid reflux
Prosthetic cardiac valve	Cancer/Tumor	Eating disorder
Previous infective endocarditis	Type of Cancer _____	Glaucoma/Eye problems
Pacemaker	Are you currently undergoing cancer treatment? Yes No	Osteoporosis
High blood pressure	Lumps/Swollen glands	Arthritis Where? _____
High cholesterol	Shortness of breath	Artificial joints Year? _____
Stroke	Hay fever/Asthma How often? _____	Diabetes Type I Insulin Dependent
Thyroid Disease	Chronic Obstructive Pulmonary Disease	Diabetes Type II
Overactive? Underactive?	(COPD)	Current HbA1C _____
Sickle Cell disease	Emphysema	Sudden Weight Loss
Abnormal prolonged bleeding	Tuberculosis (TB)	Anemia/Blood diseases
Blood transfusion	Persistent cough	HIV Infection/AIDS
Platelet Disorder or low platelet count	Hepatitis Type? _____	Venereal disease (STD)
Hemophilia	Jaundice/Liver Problems	Herpes/Cold Sores
Depression	Kidney/Bladder problems	Scalp/Skin disease
Anxiety	Dialysis	Down Syndrome
Mental/Emotional Health	Indwelling catheter/shunt	Leukemia

Do you have any **diseases** or problems **not mentioned** above, please list:

_____

What are the **expectations** and/or **concerns** you would like to discuss with the dentist?_____

_____

I certify that to the best of my knowledge the above information is complete and accurate. When there are changes to my health or medications, **I will inform my dentist and/or dental hygienist.**

Signature of Patient/Guardian: _____ Date: _____

Signature of Dental Provider _____ Date: _____