DENTALHOUSE
COME AS PATIENTS, LEAVE AS FAMILY

SIX-MONTH HEALTH HISTORY FORM

PATIENT INFORMATION:

Last Name _____ First Name _____ Middle Initial _____ Cellphone _____

Today's Date _____ Home Phone _____

[Please fill out below what has changed in the past six months or since your last visit.]

Home Address _____

Employer / School _____ Occupation / Title _____ Work Phone / Extension _____

Driver License Number _____ Social Security Number _____ Email Address _____ Gender: ☐ M ☐ F

If PATIENT IS A MINOR, INFORMATION OF RESPONSIBLE PARTY:

Last Name _____ First Name _____ Middle Initial _____ Best Contact Number _____ Birth Date _____

Relationship to Patient _____ Home Address _____

Driver License Number _____ Social Security Number _____ Occupation / Employer _____ Gender: ☐ M ☐ F

DENTAL INSURANCE:

Insurance Name _____ Address _____

Policy Holder's Name _____ Policy Holder's Social Sec # _____ Member Number _____ Group Number _____

EMERGENCY CONTACT INFORMATION:

Name _____ Address _____

Phone _____ Relationship _____

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MEDICAL / DENTAL HISTORY:

Are you experiencing dental pain or discomfort? ..... YES NO

Are you in good general health? ..... YES NO

Do you smoke or use tobacco products? ..... YES NO

Women: Are you pregnant or suspect you might be? ..... YES NO

Has there been a change in your general health within the past year? ..... YES NO

Please explain: _____

Are you under the care of a physician? ..... YES NO

If so, what condition is being treated? _____

Physician's Name _____ Phone Number _____

Please check any of the following that apply:

- ☐ AIDS (AI)
- ☐ Alcoholism (AL)
- ☐ Anemia (AN)
- ☐ Angina (AG)
- ☐ Artificial Heart Valve (AV)
- ☐ Artificial Joints (AJ)
- ☐ Arthritis / Rheumatism (AR)
- ☐ Asthma (A)
- ☐ Birth Control (BC)
- ☐ Blood Pressure – High (BH)
- ☐ Blood Pressure – Low (BL)
- ☐ Blood Thinners (BT)
- ☐ Bruise Easily (BB)
- ☐ Cancer (CA)
- ☐ Chemotherapy / Radiation (CR)
- ☐ Congenital Heart Disease (CH)
- ☐ Deaf (DF)
- ☐ Diabetes (DB)
- ☐ Drug Dependency (DD)
- ☐ Eating Disorder (ED)
- ☐ Emphysema (EM)
- ☐ Epilepsy (EP)
- ☐ Fainting / Dizziness (FD)
- ☐ Fever Blisters / Cold Sores (FS)
- ☐ Gag Easily (GE)
- ☐ Glaucoma (GL)
- ☐ Headaches – Frequent (HF)
- ☐ Heart Attack (HA)
- ☐ Heart Murmur (HM)
- ☐ Hemophilia (HP)
- ☐ Hepatitis (H)
- ☐ Hereditary Dis. / Deformities (HD)
- ☐ HIV Positive (VP)
- ☐ Herpes (HR)
- ☐ Hives (HI)
- ☐ Hyper Activity (HY)
- ☐ Hypoglycemia (HG)
- ☐ Jaundice (JC)
- ☐ Kidney/Liver Disease (KL)
- ☐ Mitral Valve Prolapse (HV)
- ☐ Night Sweats (NS)
- ☐ Osteoporosis (OS)
- ☐ Paralysis (PL)
- ☐ Prolonged Bleeding (PB)
- ☐ Psychiatric Treatment (PT)
- ☐ Rheumatic Fever (RF)
- ☐ Sexually Transmitted Disease (STD)
- ☐ Sickle Cell Disease (SD)
- ☐ Sinus Trouble (ST)
- ☐ Stroke (SK)
- ☐ Tuberculosis (TB)
- ☐ Tumors (TM)

Have you had any other serious illness(es) in the past six months? ☐ Yes ☐ No

If yes to any of the above, please explain: _____

_____

DRUGS / MEDICATIONS:

Are you allergic to or have you had a bad reaction to:

- ☐ Aspirin (AA)
- ☐ Barbiturates (AB)
- ☐ Codeine (AC)
- ☐ Erythromycin (AE)
- ☐ Iodine (AD)
- ☐ Keflex (AK)
- ☐ Local Anesthetic (LA)
- ☐ Nitrous Oxide (NO)
- ☐ Narcotics (NA)
- ☐ Penicillin (AP)
- ☐ Sulfa (AS)
- ☐ Tetracycline (AT)
- ☐ Latex
- ☐ Other Allergies: _____

_____

Have you taken any medication in the last six months? ☐ Yes ☐ No

Please list: _____

Please list any medication(s) you are taking now: _____

Reason(s): _____

_____

_____