Advantage Dental
From DentaQuest

HEALTH HISTORY FORM

Patients 14 years and older

Last Name	First Name	MI	Suffix (circle one) Sr / Jr / I / II / III	Preferred Name
Address	City		State	Zip
Mailing Address (if different)	City		State	Zip

Contact Information: Please provide all phone numbers and email.

Email _____ Cell _____ Alternative Phone _____

By providing the contact information above you are consenting to receiving electronic communications from Advantage Dental from DentaQuest about your appointments and treatment.

DENTAL AND HEALTH HISTORY

What is the reason for your dental visit today? ☐ EXAMINATION ☐ EMERGENCY ☐ CONSULTATION ☐ PROCEDURE

How would you describe your current dental health? _____

Date of your last dental visit (Month/Year): _____ ☐ EXAM ☐ EMERGENCY ☐ CONSULTATION ☐ PROCEDURE

☐ OTHER _____

Have you had any problems with previous dental treatment? ☐ YES ☐ NO If yes, please specify: _____

Do you have any pain clicking, popping, discomfort, or limited opening in the jaw or jaw joints? ☐ YES ☐ NO

If yes specify: _____

How often do you brush your teeth? ☐ NEVER ☐ SOMETIMES ☐ ONCE A DAY ☐ TWICE A DAY ☐ MORE THAN TWICE A DAY

How often do you floss your teeth? ☐ NEVER ☐ SOMETIMES ☐ ONCE A DAY ☐ ONCE A WEEK ☐ MORE THAN ONCE A DAY

Do your gums bleed when you brush or floss? ☐ NEVER ☐ SOMETIMES ☐ ALWAYS

Please state any questions or concerns about dentistry or your dental health: _____

Are you currently experiencing dental pain or discomfort?	YES	NO	Do you have any loose teeth?	YES	NO
Are you unhappy with your smile or the appearance of your teeth?	YES	NO	Do you have headaches, earaches, or neck pains?	YES	NO
Do you want a brighter whiter smile?	YES	NO	Are you worried about losing your teeth?	YES	NO
Do you have problems with eating (trouble chewing, vomiting, etc.)?	YES	NO	Do you clench, brux, or grind your teeth?	YES	NO
Do you have bad breath/ halitosis, metallic taste, or unpleasant taste?	YES	NO	Are your teeth sensitive to cold, hot, sweets or pressure?	YES	NO
Do you have any obstacles to cleaning or caring for your teeth?	YES	NO	Does food or floss catch between your teeth?	YES	NO
Have you ever had a serious injury to your head or mouth	YES	NO	Have you ever had orthodontic (braces) treatments?	YES	NO
Do you have bridges or wear dentures or partials?	YES	NO	Do you have swelling in or around your mouth, face, or neck?	YES	NO

Provide details to all YES answers here:

Do you have, or have you had any of the following? (Circle yes or no for each) For each yes, provide details below where indicated			
Acid Reflux/GERD YES NO	Cortisone Medicine YES NO	Heart Pacemaker YES NO	Psychiatric Care YES NO
AIDS/HIV Positive YES NO	Depression YES NO	Heart Trouble/Disease YES NO	Radiation Treatment YES NO
Alzheimer's Disease YES NO	Developmental Disorder YES NO	Hemophilia YES NO	Recent Weight Loss YES NO
Anaphylaxis YES NO	Diabetes YES NO	Hepatitis A YES NO	Renal Dialysis YES NO
Anemia YES NO	Drug Addiction YES NO	Hepatitis B or C YES NO	Rheumatic Fever YES NO
Angina/Chest Pain YES NO	Easily Winded/Shortness of Breath YES NO	Herpes YES NO	Rheumatism YES NO
Arthritis/Gout YES NO	Eating Disorder YES NO	High Blood Pressure YES NO	Scarlet Fever YES NO
Artificial Heart Valve YES NO	Emphysema YES NO	Human Papillomavirus (HPV) YES NO	Sexually Transmitted Disease YES NO
Artificial Joint YES NO	Epilepsy or Seizures/Convulsions YES NO	Hypoglycemia YES NO	Shingles YES NO
Asthma YES NO	Excessive Bleeding YES NO	Irregular Heartbeat YES NO	Sickle Cell Disease YES NO
Blood Transfusion YES NO	Excessive Thirst YES NO	Kidney Problems YES NO	Sinus Trouble YES NO
Bruise Easily YES NO	Fainting spells/Dizziness YES NO	Leukemia YES NO	Stomach/Intestinal Disease YES NO
Cancer YES NO	Frequent Cough YES NO	Liver Disease YES NO	Stroke YES NO
Chemotherapy YES NO	Frequent Diarrhea YES NO	Low Blood Pressure YES NO	Thyroid Disease YES NO
Circulatory Problems YES NO	Frequent Headaches YES NO	Lung Disease YES NO	Tuberculosis YES NO
Cold Sores/Fever Blisters YES NO	Glaucoma YES NO	Mitral Valve Prolapse YES NO	Tumor or Growths YES NO
Congenital Heart Disorder YES NO	Heart Attack/Heart Failure YES NO	Osteoporosis YES NO	Yellow Jaundice YES NO
COPD YES NO	Heart Murmur YES NO	Parathyroid Disease YES NO	Ulcers YES NO

Provide details to all YES answers here:

_____

_____

If you have TB is it active? ☐ YES ☐ NO If yes, what medication are you on: _____

Are you taking, have you recently taken (within the last month), or are you supposed to be taking any medications? ☐ YES ☐ NO
(Prescription, over the counter, diet supplements, vitamins, natural, or herbal)

If yes, please specify medication(s), dosage, and frequency (If you take more than 4 medications, please provide us with a written list of all medications)

Medication Prescription or Over the Counter	**Dosage/Frequency**	**Supplements** Diet supplements, vitamins (natural or herbal)	**Dosage/Frequency**

PLEASE CIRCLE YOUR RESPONSES YES or NO TO INDICATE IF YOU HAVE OR HAVE NOT HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS

Are you now, or have you been in the past year, under the care of a physician? ☐ YES ☐ NO

If yes, what is/are the condition(s) being treated? _____

Have you had an organ transplant? If yes, please specify: ☐ YES ☐ NO

☐ HEART ☐ KIDNEY ☐ LIVER ☐ LUNG ☐ OTHER (SPECIFY): _____

Have you had an orthopedic total joint (e.g., hip, knee, elbow, finger) replacement? ☐ YES ☐ NO

If yes, what joint was replaced? _____ If yes, when (Month/Year)? _____

Have you ever had any radiation therapy or chemotherapy for a growth, tumor, or other condition? ☐ YES ☐ NO

If yes please specify: _____

In the last 2 years, have you taken or are you now taking steroids (e.g. cortisone)? ☐ YES ☐ NO

If yes please specify: _____

Have you taken, are you taking, or are you scheduled to begin taking: Oral bisphosphonates? ☐ YES ☐ NO

(Alendronate (Fosamax, Fosamax Plus D), Etidronate (Didronel), Ibandronate (Boniva), Risedronate (Actonel), Tiludronate (Skelid)?

If yes, what drug, dose, and frequency? _____

Have you taken, are you taking, or are you scheduled to begin taking intravenous bisphosphonates?:

Clodronate (Bonefos), Pamidronate (Aredia), or Zoledronic Acid (Reclast, Zometa)? ☐ YES ☐ NO

What drug, dose and frequency? _____ What for? _____ When was last dose? _____

Do you normally take an antibiotic prior to dental treatment? ☐ **YES** ☐ **NO**

TOBACCO

Do you use or have you used tobacco (smoking, snuff, chew, bidis)? ☐ NEVER ☐ PAST ☐ CURRENTLY

HOW INTERESTED ARE YOU IN STOPPING? ☐ **VERY** ☐ **SOMEWHAT** ☐ **NOT INTERESTED**

DRUGS/ALCOHOL

Do you use recreational drugs or prescription medication for non-medical reasons? ☐ YES ☐ NO

Do you use alcohol on a regular basis? ☐ YES ☐ NO

ALLERGIES

Are you allergic to any medications, metal, latex or certain materials? ☐ YES ☐ NO If so what are they? _____

DIABETIC PATIENTS

Diabetic Patients (please answer): When was your last A1C (blood sugar test)? _____ What was the number? _____

WOMEN ONLY

Are you pregnant? ☐ YES ☐ NO If yes, number of weeks: _____ Are you nursing? ☐ YES ☐ NO

Are you trying to become pregnant? ☐ YES ☐ NO

OTHER

Are there any other health conditions that you would like to make us aware of to improve our delivery of care and better meet your oral health care needs?

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Signature of Patient or Guardian Date

_____ _____

Print Name Relationship to Patient

OFFICE USE

Blood Pressure: _____/_____ Pulse: _____ Height: _____ Weight: _____ Temp: _____ Date: _____

HEALTH HISTORY REVIEWED BY _____

PROVIDER'S SIGNATURE **DATE**