Name:_____ DOB:_____

Ankeny Dental Associates

Health History Form

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your responses to this questionnaire are vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Do you have Active tuberculosis or a cough that produces blood?☐ Yes ☐ No**If yes, please return form to receptionist**.

Do your gums bleed when you brush or floss?	☐ Yes ☐ No	Do you have sores or ulcers in your mouth?	☐ Yes ☐ No
Have you had any periodontal (gum) treatment?	☐ Yes ☐ No	Have you had a injury to your head or mouth?	☐ Yes ☐ No
Do you brux or grind your teeth?	☐ Yes ☐ No	Is your mouth dry?	☐ Yes ☐ No
Are you currently experiencing dental pain?	☐ Yes ☐ No	Are you dissatisfied with your smile?	☐ Yes ☐ No
Are your teeth sensitive to cold, hot, sweets or pressure?	☐ Yes ☐ No	Have you had any problems with previous dental treatment?	☐ Yes ☐ No

Date of your last dental exam and what was done?_____

Current primary care physician's name and office location?_____

Have you had a serious illness, operation or been hospitalized in the past 5 years?☐ No ☐ Yes,_____

Since 2005, have you or will you be treated with an antiresorptive agent (like Fosamax, Boniva, Reclast, Prolia, Zometa,XGEVA, etc.) for osteoporosis, Paget's disease, multiple myeloma or metastatic cancer?☐ No ☐ Yes,_____

Are you taking any vitamins or dietary supplements?☐ No ☐ Yes,_____

Are you taking any prescriptions or medicine?☐ No ☐ Yes, _____

_____

Do you use tobacco (smoking, snuff, chew)?☐ No ☐ Yes

Do you use controlled substances?☐ No ☐ Yes,

Women: Are you…

☐Pregnant/Trying to get pregnant?	☐Nursing?	☐Taking oral contraceptives?

Are you allergic to any of the following?

☐Penicillin	☐Other Antibiotics	☐Metal	☐Latex
☐Sulfa Drugs	☐Local Anesthetics	☐Codeine	☐Other:_____

Do you have, or have you had, any of the following?

☐Previous infective endocarditis	☐Damaged valves in transplanted heart	
Congenital heart disease (CHD):		
☐Unrepaired, cyanotic CHD	☐Repaired (completely) in last 6 months	☐Repaired CHD with residual defects

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

☐Cardiovascular disease	☐Abnormal bleeding	☐Tuberculosis	☐Fainting spells
☐Angina	☐Anemia	☐Chest pain upon exertion	☐Epilepsy
☐Arteriosclerosis	☐Blood transfusion	☐Chronic pain	☐ Seizures
☐Heart failure	☐Hemophilia	☐Diabetes Type I or II	☐ Neurological disorders
☐Damaged heart valves	☐AIDS or HIV infection	☐Eating disorder	☐ Sleep Disorder
☐Heart attack	☐Arthritis	☐Malnutrition	☐ Do you snore?
☐ Heart murmur	☐ Autoimmune disease	☐ Gastrointestinal disease	☐ Mental health disorders
☐ Low blood pressure	☐ Rheumatoid arthritis	☐ G.E. Reflux/persistent heartburn	☐ Recurrent infections
☐ High blood pressure	☐ Systemic lupus erythematosus	☐ Ulcers	☐ Night sweats
☐ Other congenital heart defects	☐ Asthma	☐ Thyroid problems	☐ Osteoporosis
☐ Mitral valve prolapse	☐ Bronchitis	☐ Stroke	☐ Severe headaches/migraines
☐ Pacemaker	☐ Emphysema	☐ Glaucoma	☐ Severe or rapid weight loss
☐ Rheumatic fever	☐ Sinus trouble	☐ Kidney problems	☐ Sexually transmitted disease
☐ Rheumatic heart disease	☐ Cancer	☐ Hepatitis (A, B or C)	☐ Excessive urination
☐ Joint replacement (Hip, knee, elbow, finger)	☐ Chemotherapy/Radiation Treatment	☐ Jaundice or liver disease	☐ Persistent swollen glands in neck

Do you have any disease, condition, or problem not listed above that you think we should know about?_____

_____

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 health. It is my responsibility to inform the dental office of any changes in medical status.

_____

Signature of Patient, Parent or Guardian Print Nam e Date