# Health History



| First Name | Middle | Last Name |
|---|---|---|
| | | |

| Date of Birth | Socal Security # | Sex | Email |
|---|---|---|---|
| | | | |

| Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Home Phone | Cell Phone | Emergency Contact (Full Name) | Emergency Contact Phone |
|---|---|---|---|
| | | | |

| Employer | Occupation | Work Phone |
|---|---|---|
| | | |

Please tell us why you are here today.

Whom may we thank for your referral?

**Medical History**

| | Yes | | Yes |
|---|---|---|---|
| Natural Blood Thinners (fish oil, omega 3, etc) | ☐ | Prescription Blood Thinners (apixaban, dabigatran, aspirin, etc) | ☐ |
| Has a physician told you to take antibiotics prior to a dental procedure (Premedication/ Antibiotic prophylaxis)? | ☐ | | |

| | |
|---|---|
| Currently under the care of a physician/specialist? (Please list) | |
| Natural Remedies, Vitamins, Over the Counter Medications | |
| Are you being seen for pain management? (List Current Doctor) | |
| Physical Disabilities/Deformities (Please Describe) | |
| Known Medication side effects? (Please Describe) | |

Please list ALL Medications (Name, Dosage and Frequency)

**Hospital/Surgery History**

| | |
|---|---|
| Any complications due to surgical/medical care? (Please describe) | |
| Complication(s) with Sedation/Anesthesia? (Please describe) | |

**Cancer (Currently Has)**

| | Yes | | Yes | | Yes |
|---|---|---|---|---|---|
| Brain | ☐ | Leukemia | ☐ | Skin | ☐ |
| Breast | ☐ | Lung | ☐ | Thyroid | ☐ |
| Esophagus | ☐ | Lymphoma | ☐ | Tongue | ☐ |
| Kidney | ☐ | Oral Cavity, Lip or Floor of Mouth | ☐ | | |
| Receiving Chemotherapy | ☐ | Receiving Radiation | ☐ | | |
| Other (Please describe) | | | | | |

**Cancer (Previously Diagnosed)**

| | Yes | | Yes | | Yes |
|---|---|---|---|---|---|
| Brain | ☐ | Leukemia | ☐ | Skin | ☐ |
| Breast | ☐ | Lung | ☐ | Thyroid | ☐ |
| Esophagus | ☐ | Lymphoma | ☐ | Tongue | ☐ |
| Kidney | ☐ | Oral Cavity, Lip or Floor of Mouth | ☐ | | |
| Receiving Chemotherapy | ☐ | Receiving Radiation | ☐ | | |
| Other (Please describe) | | | | | |

| Hepatitis | Yes |
|---|---|
| A | ☐ |
| B | ☐ |
| C | ☐ |

| Personal History | Yes |
|---|---|
| Arthritis | ☐ |
| Epilepsy | ☐ |
| Fibromyalgia | ☐ |
| HIV/AIDS | ☐ |
| Kidney Disease | ☐ |
| Liver Disease | ☐ |
| Lupus | ☐ |
| Mental and Behavioral Disorders | ☐ |
| Osteoporosis (Age Related) | ☐ |
| Osteoporosis (Drug Related) | ☐ |
| PTSD (Post-traumatic Stress Disorder) | ☐ |
| Seizures | ☐ |
| Shingles | ☐ |
| Sickle Cell Disease | ☐ |
| Sjogren's syndrome | ☐ |
| Trigeminal Neuralgia (Facial Nerve Pain) | ☐ |
| Tuberculosis | ☐ |

| Allergies | Yes |
|---|---|
| Aspirin | ☐ |
| Acrylic | ☐ |
| Codeine | ☐ |
| Latex | ☐ |
| Local Anesthetics | ☐ |
| Metal | ☐ |
| Penicillin/Amoxicillin | ☐ |
| Seasonal Allergies | ☐ |
| Sulfa Drugs | ☐ |
| Other Allergies Not Mentioned (List Below): | ☐ |

| Blood Related Conditions | Yes |
|---|---|
| Anemic | ☐ |
| Bruises Easily | ☐ |
| Conditions of Spleen | ☐ |
| Increased Risk of Bleeding | ☐ |

| Injury/Trauma to Face/Mouth | Yes |
|---|---|
| Face | ☐ |
| Head | ☐ |
| Lip | ☐ |
| Mouth (Oral Cavity) | ☐ |

| Mouth | Yes |
|---|---|
| Bad Breath | ☐ |
| Bleeding Gums | ☐ |
| Canker Sores | ☐ |
| Difficulty controlling mouth, lip and tongue to control food/liquid | ☐ |
| Difficulty Swallowing | ☐ |
| Excessive Thirst | ☐ |

| Dry Mouth | Yes |
|---|---|
| Substitute Treatment attempted: Sugar Free Gum, Sip Water, or Saliva | ☐ |

| Do you get Headaches or Migraines? | Yes |
|---|---|
| Frequent Headaches | ☐ |
| Migraines | ☐ |
| Tension Headaches | ☐ |

| Pain when Chewing | Yes |
|---|---|
| Left Side | ☐ |
| Right Side | ☐ |
| Both Sides | ☐ |

| Type 1 Diabetic | Yes |
|---|---|
| Controlled | ☐ |
| Uncontrolled Low Blood Sugar (Hypo) | ☐ |
| Uncontrolled High Blood Sugar (Hyper) | ☐ |
| Insulin Dependent | ☐ |
| Taking Insulin | ☐ |

| Type 2 Diabetic | Yes |
|---|---|
| Controlled | ☐ |
| Uncontrolled Low Blood Sugar (Hypo) | ☐ |
| Uncontrolled High Blood Sugar (Hyper) | ☐ |
| Insulin Dependent | ☐ |
| Taking Insulin | ☐ |

| Intestinal and Digestive | Yes |
|---|---|
| Acid Reflux | ☐ |
| GERD | ☐ |
| History of Anorexia Nervosa | ☐ |
| History of Bulimia Nervosa | ☐ |
| Recent Weight Gain | ☐ |
| Recent Weight Loss | ☐ |
| Stomach Ulcers | ☐ |

| Tobacco Use | Yes |
|---|---|
| Currently uses Tobacco (cigarettes, cigars, vapes, smokeless tobacco) | ☐ |
| Not currently using Tobacco, but have a History of using cigarettes, cigars, vapes, smokeless tobacco | ☐ |

| Drugs (Current or Historical) | Yes |
|---|---|
| Alcohol Abuse (Current or Historical) | ☐ |
| Cocaine | ☐ |
| Ecstasy/PCP | ☐ |
| Heroin | ☐ |
| Marijuana | ☐ |
| Methamphetamine | ☐ |
| Opioids | ☐ |
| Other (please list) | ☐ |

| Stroke/Bell's Palsy | Yes |
|---|---|
| Bell's Palsy | ☐ |
| Facial Weakness | ☐ |
| Left Side Weakness (Left Hand Dominant) | ☐ |
| Left Side Weakness (Right Hand Dominant) | ☐ |
| Right Side Weakness (Left Hand Dominant) | ☐ |
| Right Side Weakness (Right Hand Dominant) | ☐ |

| Heart Conditions | Yes |
|---|---|
| Artificial Heart Valves | ☐ |
| COPD (Constructive Obstructive Pulmonary Disease) | ☐ |
| Frequently experience light headedness/dizziness? | ☐ |
| Heart Disease | ☐ |
| Heart Failure | ☐ |
| High Blood Pressure | ☐ |
| High Cholesterol | ☐ |
| History of Chest Pain/Pressure | ☐ |
| History of Heart Attack | ☐ |
| Low Blood Pressure | ☐ |
| Pacemaker | ☐ |
| Shortness of Breath | ☐ |
| Swelling of the Ankles | ☐ |
| Have you ever been told you have a heart murmur? | ☐ |
| Taken Fen Phen or Redux? If so, have you had your heart examined by a Physician and when? | ☐ |

| Thyroid Conditions | Yes |
|---|---|
| Cyst on Thyroid | ☐ |
| Enlarged Thyroid | ☐ |
| Hyperthyroid | ☐ |
| Hypothyroid | ☐ |

| Eye/Ear/Nose/Throat | Yes |
|---|---|
| Blurry Vision | ☐ |
| Broken Nose | ☐ |
| Clogged Sinuses | ☐ |
| Deviated Septum | ☐ |
| Frequent Sinus Infections | ☐ |
| Nasal Congestion | ☐ |
| Trouble Breathing through your Nose | ☐ |

| Ringing in Ears | Yes |
|---|---|
| Left | ☐ |
| Right | ☐ |
| Both | ☐ |

| Pain in Your Ears | Yes |
|---|---|
| Left | ☐ |
| Right | ☐ |
| Both | ☐ |

| Hearing Loss | Yes |
|---|---|
| Left | ☐ |
| Right | ☐ |
| Both | ☐ |

| Respiratory Conditions | Yes |
|---|---|
| Asthma | ☐ |
| Chronic Coughing | ☐ |
| COPD | ☐ |
| Fainting Spells | ☐ |
| History of Bronchitis | ☐ |
| Lung Disease | ☐ |

| Sleep Related Conditions | Yes |
|---|---|
| CPAP Goes without using Regularly | ☐ |
| Uses CPAP | ☐ |
| Do you mouth breath? | ☐ |
| History of Narcolepsy | ☐ |
| History of Thumb Sucking | ☐ |
| Insomnia | ☐ |
| Sleep Apnea | ☐ |
| Sleep Study Performed | ☐ |
| Snoring | ☐ |

| Jaw and Joint | Yes |
|---|---|
| Dislocated Jaw Pain (History of) | ☐ |
| Grind your Teeth | ☐ |
| Muscle Spasms | ☐ |
| Pain Upon Awakening | ☐ |
| Do you have any pain from a serious head or neck injury? | ☐ |

| Pain upon Opening Mouth | Yes |
|---|---|
| Left Side | ☐ |
| Right Side | ☐ |
| Both Sides | ☐ |

| Dislocated Jaw (Current) | Yes |
|---|---|
| Left Side | ☐ |
| Right Side | ☐ |
| Both Sides | ☐ |

| Jaw Pain | Yes |
|---|---|
| Left Side | ☐ |
| Right Side | ☐ |
| Both Sides | ☐ |

| Swelling in Jaw | Yes |
|---|---|
| Left Side | ☐ |
| Right Side | ☐ |
| Both Sides | ☐ |

| Clicking or Popping of Jaw Joint | Yes |
|---|---|
| Left Side | ☐ |
| Right Side | ☐ |
| Both Sides | ☐ |

| Are you Female? | Yes |
|---|---|
| Nursing or Pumping | ☐ |
| Pregnant or Trying to get Pregnant | ☐ |
| Reached Menopause | ☐ |
| Taking Contraceptives or other Hormones | ☐ |
| Taking Bisphosphonates (aka Boniva, Fosamax, Actonel) | ☐ |

## Medical Release

Without specific permission, we WILL NOT release any medical information to anyone other than you. In some cases, you may wish for another person to have access to your medical information. Please identify those individuals and their relationship to you (spouse, child, mother etc). We will, however, release information to another doctor to aid in your care.

**Name** **Relation**

_____ _____

_____ _____

## Consent

I attest that I have answered every question completely and accurately to the best of my knowledge. I will inform my dentist of changes in my health, my health history, and/or medication. I certify that I consent to taking x-rays and an oral examination. I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I understand that my dentist will explain the purpose of the services and that I have the right to refuse any recommended services.

_____ **(Initial Here)**

I authorize the release of all medical information necessary to process my claims and for the purpose of payment, treatment and operations. I authorize payment directly to the dentist of insurance benefits otherwise payable to me. I assign the benefits payable for services to the dentist furnishing the services. In consideration of services, I agree and understand that my insurance may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. I authorize release of my protected health information, when necessary, to other providers rendering medical/dental care, for pharmaceutical purposes, as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

_____ **(Initial Here)**

This authorization will remain in effect until revoked by me in writing. A photocopy of my authorizations is to be considered as valid as the original.

_____ **(Initial Here)**

_____ _____ _____

**Signature of Patient or Legal Guardian** **Print Name** **Dated**

## Medical Release

| Name | Release |
| --- | --- |
| | |
| | |
| | |
| | |
| | |

*Important: You assume responsibility to notify the office of phone number(s) changes or changes to the individuals which you wish to share your medical information with.*

## Consents

By selecting 'Yes', I attest that I have answered every question completely and accurately to the best of my knowledge. I will inform my doctor of any changes in my health, my health history, and/or medication. I certify that I consent to taking x-rays and an oral examination. I consent to the diagnostic procedures and treatment by the doctor necessary for proper oral care. I understand that my doctor will explain the purpose of any recommended services and that I have the right to refuse any recommended services.

**[ ] Initial Here**

By selecting 'Yes', I authorize the release of all medical information necessary to process my claims and for the purpose of payment, treatment and operations. I authorize payment directly to the doctor of insurance benefits otherwise payable to me. I assign the benefits payable for services to the doctor furnishing the services. In consideration of services, I agree and understand that my insurance may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. I authorize release of my protected health information, when necessary, to other providers rendering health care, for pharmaceutical purposes, as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

**[ ] Initial Here**

By selecting 'Yes', this authorization will remain in effect until revoked by me in writing. A photocopy of my authorizations is to be considered as valid as the original.

**[ ] Initial Here**

By selecting 'Yes', I agree to receive text messages from Boise Dentistry Co.. Standard message and data rates apply.

**[ ] Initial Here**

| Signature of Patient or Legal Guardian | Print Name | Dated |
| --- | --- | --- |