



NEWBURY DENTAL

Preference for Appointment Reminders (check one)

- Text E-mail Phone Call

HEALTH HISTORY FORM

Dr. Mr. Mrs. Ms.

Name: _____
first middle last

Date of Birth: _____ Age: _____
mm/dd/yyyy

Physician's Name: _____ Physician's Number: _____

Emergency Contact Information

<i>Name</i>	<i>Relation</i>	<i>Phone</i>
How did you hear about Newbury Dental	<input type="checkbox"/> Website <input type="checkbox"/> Google	Referral: _____
Have you been hospitalized in the last 5 years?.....	Y OR N	Explain: _____
Have you ever had extensive medical care or surgery?.....	Y OR N	Explain: _____
Do you have any allergies? (i.e. antibiotics, metal, latex).....	Y OR N	Explain: _____
When was your last physical exam with your family doctor(approx.)? _____		

Have you ever experienced any unusual reactions to the following? (please check all that apply)

- Local Anesthetics(freezing) Aspirin Penicillin Iodine Sulfonamide(Sulfa) Barbiturates

Explain: _____

Have you ever been advised to not take a certain drug/medication..... **Y OR N**

Explain: _____

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

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Heart Murmur or Mitral Valve Prolapse | <input type="checkbox"/> Malignant Hyperthermia | <input type="checkbox"/> AIDS | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Stomach/Intestinal Problems | <input type="checkbox"/> Drug/Alcohol Addiction | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Hepatitis A or B or C | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Mental or Nervous Disorder | <input type="checkbox"/> Cortisone/Steroid Therapy | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Cold Sores |
| <input type="checkbox"/> High or Low Blood Pressure | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Hyper/Hypoglycemia | <input type="checkbox"/> Arthritis or Rheumatism | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Scarlet or Rheumatic Fever | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney Disease |

Notes: _____

Have you ever had any known contact with the HIV..... **Y OR N** Explain: _____

Has any member of your family had diabetes..... **Y OR N** Explain: _____

Do your ankles swell during the day?..... **Y OR N** Explain: _____

Have you had any sudden weight changes recently?..... **Y OR N** Explain: _____

Do you bruise easily?..... **Y OR N** Explain: _____

Do you have any blood disorders? (i.e. haemophilia, anemia)... **Y OR N** Explain: _____

Do you bleed for a prolonged period after a cut/wound?..... **Y OR N** Explain: _____

Have you ever had chemotherapy?..... **Y OR N** Explain: _____

Have you had radiation to the head or neck?..... **Y OR N** Explain: _____

Have you ever fainted?..... **Y OR N** Explain: _____

Do you ever experience shortness of breath? Or Chest Pain?.... **Y OR N** Explain: _____

Have you had any organ transplants or medical implants?..... **Y OR N** Explain: _____

Is your eye sight : Good Adequate Poor

Do you have any disease, condition or past medical history that the doctor should know about? **Y OR N**

Explain: _____

Have you ever been diagnosed with or treated for Osteoporosis or Osteopenia?...**Y OR N** Explain: _____

Have you ever taken any of the following medications? (check all that apply)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Etidronate(Didronel) | <input type="checkbox"/> Risedronate (Actonel) | <input type="checkbox"/> Denosumab (Prolia) | <input type="checkbox"/> Alendronate (Fosamax) |
| <input type="checkbox"/> Tiludronate (Skelid) | <input type="checkbox"/> Ibandronate (Boniva) | <input type="checkbox"/> Zoledronate (Zometa) | |

Female Patient Only

Are you pregnant?.....Y OR N How Many Months Pregnant: _____ Name of Obstetrician: _____

Please list all prescriptions and non-prescriptions Please include dose and the frequency

Medications	Approx. Start Date	Medications	Approx. Start Date
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Dental History

How often have you visited the dentist 3 mos. 6 mos. 9 mos. Once a year

Name of Former Dentist (if known): _____ Last Dental Visit (approx.) _____

Do you like your smile?.....Y OR N Is there anything you want to change/improve? Explain: _____

Have you been given oral hygiene instruction in brushing?..... Y OR N.. How often do you brush? _____

Have you been given oral hygiene instruction in flossing?..... Y OR N.. How often do you floss? _____

Are your teeth sensitive?..... Y OR N.. Location: _____

Do your gums bleed?..... Y OR N.. Spontaneously Only when brushing/flossing

Do you gag easily?..... Y OR N.. Mild Severe

Do you chew on one side only?..... Y OR N.. Explain: _____

Have you had any growths or sores in your mouth?..... Y OR N.. Explain: _____

Do you smoke?..... Y OR N.. cigarette marijuana other Pack per day: _____

TMJ Screening

Do you ever wake up with a headache, muscle pain or sore jaw?.....Y OR N.. **Notes:** _____

Are you aware of clenching/grinding your teeth at all through the day/night?.....Y OR N.. _____

Do you currently wear a night guard or any other dental apparatus?.....Y OR N.. _____

Do you snore heavily throughout the night?.....Y OR N.. _____

Have you ever experienced lockjaw?.....Y OR N.. _____

Does your jaw crack or pop when opening/closing?.....Y OR N.. _____

Check all of the following that you are interested in:

- Orthodontics
- Snoring/Apnea treatment
- Replace missing teeth
- Repair chipped teeth
- Improve bite
- Implants
- Improve gum health
- Closing spaces
- Sports guard
- Whitening
- Improve smile
- Crowns

I hereby certify that the above information is accurate and complete and that I have not knowingly omitted any information. I have had the opportunity to ask question and receive answers to any questions regarding my medical-dental history. Should there be any change in either my health status or any other information I have provided, I will advise this dental office. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that the information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy.

X _____ Date: _____
Signature of Patient/or Guardian (18yrs & under) mm/dd/yyyy

X _____ Date: _____
Please Print Name of Patient/or Guardian (18 yrs & under) mm/dd/yyyy