Hamann Family Dentistry's Health History Form

Patient Information

Patient Name: _____ Date: _____

E-Mail Address: _____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Child

Social Security Number: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Address: _____
Street Apt. #

_____
City State Zip code

Referral Information

Whom may we thank for referring you to our practice?

☐ Another patient, friend: _____ ☐ Another patient, relative: _____

☐ Yellow Pages/Phone Book ☐ Newspaper ☐ Work ☐ Website ☐ Insurance ☐ Location

☐ Employee of Hamann Family Dentistry: _____ ☐ Other: _____

Employment Information

Employer Name: _____ Occupation: _____

Emergency Contact Information

Name: _____ Relationship to patient: _____ Phone: _____

Health Information

Date of Last Dental Visit: _____ Reason for Visit: _____

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies
- Codeine
- Penicillin
- Local Anesthetic
- Sulfa Drug
- Metals
- Other: _____

☐ Abnormal Bleeding
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Chemotherapy
☐ Diabetes
- Type I
- Type II

☐ Dizziness
☐ Eating Disorder
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ G.E. Reflux
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Attack
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Osteoporosis
☐ Pace Maker
☐ Pregnancy
Due Date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatism
☐ Seizures/Fainting Spells
☐ Sinus Problems
☐ Stomach problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Other:
_____
_____
_____
_____
_____
☐ Current Medications:
_____
_____
_____

Have you ever had complications following a dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

Are you under the care of a physician? ☐ Yes ☐ No
If yes, physician's name: _____ Phone: _____

Have you been admitted to a hospital or needed emergency care during the past two year? ☐ Yes ☐ No
If yes, please explain: _____

Have you had an orthopedic total joint (hip, knee, elbow) replacement? ☐ Yes ☐ No
If yes, any complications? _____ Date: _____

Are you taking or schedule to take either alendronate (Fosamax) or risedronate (Actonel) for osteoporosis?
☐ Yes ☐ No

Are you taking or presently schedules to begin treatment with the intravenous bisphosphonates (Aredia or Zometa)?
☐ Yes, date treatment began: _____ ☐ No

Are you currently taking any medication that is a blood thinner? ☐ Yes ☐ No
Name of Medication: _____ Start Date: _____

Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

Do you smoke? ☐ Yes ☐ No Do you chew tobacco? ☐ Yes ☐ No

I certify that I have read and understood the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I will not hold my dentist, or any other members of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. If changes in my health, I will inform the doctors.

Signature of patient: _____ Date: _____