Charles Drew
HEALTH CENTER, INC.
"Growing a Healthy Community"

Dental Health History Form

Patient Information

Patient Name: _____

Please answer each question **for the patient** and provide additional information when required:

Are you in good health?	☐ Yes	☐ No
Have there been any recent changes in your health?	☐ Yes	☐ No
Date of last physical exam: _____		
Are you under a physician's care for any problems?	☐ Yes	☐ No
Have you ever had any serious illnesses, operations, or hospitalizations?	☐ Yes	☐ No

FOR WOMEN PATIENTS ONLY:

Are you pregnant or is there any chance you could be?	☐ Yes	☐ No
Are you nursing?	☐ Yes	☐ No
Are you taking oral contraceptives?	☐ Yes	☐ No

Is the patient taking any of the following

Antibiotics?	☐ Yes	☐ No	Insulin or diabetic drugs?	☐ Yes	☐ No
Anticoagulants (blood thinners)?	☐ Yes	☐ No	Fosamax or biophosphonate?	☐ Yes	☐ No
Antidepressants?	☐ Yes	☐ No	Are you taking other drugs or medications?	☐ Yes	☐ No
Cortisone (steroids)?	☐ Yes	☐ No	If **yes**, which drugs/medication and how much: _____		
Medicine for high blood pressure?	☐ Yes	☐ No	_____		
Aspirin?	☐ Yes	☐ No	_____		

Is the patient allergic or has the patient adversely reacted to any of the following:

Latex?	☐ Yes	☐ No	Metals?	☐ Yes	☐ No
Local anesthetic?	☐ Yes	☐ No	Pain medication?	☐ Yes	☐ No
Penicillin?	☐ Yes	☐ No	Other: _____		

Please indicate any history of the following:

Heart surgery or artificial heart valve?	☐ Yes	☐ No	Radiation treatment to head or neck region?	☐ Yes	☐ No
Congenital heart defect?	☐ Yes	☐ No	Any bleeding conditions or disorders?	☐ Yes	☐ No
ADD/ADHD?	☐ Yes	☐ No	Fainting spells or seizures?	☐ Yes	☐ No
Heart attack?	☐ Yes	☐ No	Osteoporosis?	☐ Yes	☐ No
Stroke?	☐ Yes	☐ No	Hepatitis or jaundice?	☐ Yes	☐ No
High/low blood pressure	☐ Yes	☐ No	Kidney problems?	☐ Yes	☐ No
Asthma?	☐ Yes	☐ No	Arthritis?	☐ Yes	☐ No
Persistent or bloody cough?	☐ Yes	☐ No	Mental health issues?	☐ Yes	☐ No
Tobacco Use?	☐ Yes	☐ No	Do you have any other medical conditions?	☐ Yes	☐ No
Cancer?	☐ Yes	☐ No	If yes, please explain: _____		
Artificial joint (hip, knee) implants, prosthesis?	☐ Yes	☐ No	_____		
			_____		

I understand the importance of a truthful and complete Health History to assist my dentist in providing the best care possible. If there are any changes in my health, or medicines, I will inform my dentist at my next appointment.

Patient or Guardian's Signature: _____ Date: _____

Interpreter's Signature: _____ Date: _____