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

DENTAL HEALTH HISTORY

PATIENT INFORMATION

First Name: ______________________ Last Name: ______________________

Date of birth (mm/dd/yyyy): ______________________ Social Security Number (SSN): ______________________
Optional

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

Question	Yes	No
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 FEMALE PATIENTS ONLY

Question	Yes	No
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:

Question	Yes	No
Antibiotics?	☐ Yes	☐ No
Anticoagulants (blood thinners)?	☐ Yes	☐ No
Antidepressants?	☐ Yes	☐ No
Cortisone (steroids)?	☐ Yes	☐ No
Medicine for high blood pressure?	☐ Yes	☐ No
Aspirin?	☐ Yes	☐ No
Insulin or diabetic drugs?	☐ Yes	☐ No
Fosamax or biophosphonate?	☐ Yes	☐ No
Are you taking other drugs or medications?	☐ Yes	☐ No

If yes, which drugs/medication and how much:
____
____

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

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

Please indicate any history of the following:

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

If yes, please explain: ______________________
____

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: ____________