



**Preference for Appointment Reminders (check one)**

- Text  E-mail  Phone Call

## HEALTH HISTORY FORM

Dr.  Mr.  Mrs.  Ms.

Name: \_\_\_\_\_ Email: \_\_\_\_\_  
first middle last

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_  
mm/dd/yyyy

Address: \_\_\_\_\_  
box # house # street name city province postal code

Do you have Dental Insurance? **Y OR N**

Physician's Name: \_\_\_\_\_ Physician's Number: \_\_\_\_\_

**Emergency Contact Information**

<small>Name</small>	<small>Relation</small>	<small>Phone</small>
How did you hear about Tilbury Dental Care..... <input type="checkbox"/> Website <input type="checkbox"/> Google	Referral: _____	
Have you been hospitalized in the last 5 years?..... <b>Y OR N</b>	Explain: _____	
Have you ever had extensive medical care or surgery?..... <b>Y OR N</b>	Explain: _____	
Do you have any <b>allergies?</b> (i.e. antibiotics, metal, latex)..... <b>Y OR N</b>	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..... <b>Y OR N</b>	Explain: _____
Has any member of your family had diabetes..... <b>Y OR N</b>	Explain: _____
Do your ankles swell during the day?..... <b>Y OR N</b>	Explain: _____
Have you had any sudden weight changes recently?..... <b>Y OR N</b>	Explain: _____
Do you bruise easily?..... <b>Y OR N</b>	Explain: _____
Do you have any blood disorders? (i.e. haemophilia, anemia)... <b>Y OR N</b>	Explain: _____
Do you bleed for a prolonged period after a cut/wound?..... <b>Y OR N</b>	Explain: _____
Have you ever had chemotherapy?..... <b>Y OR N</b>	Explain: _____
Have you had radiation to the head or neck?..... <b>Y OR N</b>	Explain: _____
Have you ever fainted?..... <b>Y OR N</b>	Explain: _____
Do you ever experience shortness of breath? Or Chest Pain?.... <b>Y OR N</b>	Explain: _____
Have you had any organ transplants or medical implants?..... <b>Y OR N</b>	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