# Health History Form

**Lawrence Scott Frankel, DMD, MS, Inc.**
*Practice Limited To Periodontics*

Today's Date:

Name: Last First Middle

Home Phone: *Include area code* ( )

Business/Cell Phone: *Include area code* ( )

Address: Mailing address

City: State: Zip:

E-mail: Height: Weight: Date of birth: Sex: M F

## Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

| | Yes | No | DK |
|---|---|---|---|
| Are you now under the care of a physician? | ☐ | ☐ | ☐ |
| Physician Name: Phone: *Include area code* ( ) | | | |
| Address/City/State Zip: | | | |
| Are you in good health? | ☐ | ☐ | ☐ |
| Has there been any change in your general health within the past year? | ☐ | ☐ | ☐ |
| If yes, what condition is being treated? | | | |
| Date of last physical exam: | | | |

| | Yes | No | DK |
|---|---|---|---|
| Have you had a serious illness operation or been hospitalized in the past 5 years? | ☐ | ☐ | ☐ |
| If yes, what was the illness or problem? | | | |
| Are you taking or have you recently taken any prescription or over the counter medicine(s)? | ☐ | ☐ | ☐ |

PLEASE LIST ALL PRESCRIBED MEDICATIONS, OVER THE COUNTER MEDICATIONS, VITAMINS, HERBAL AND DIET SUPPLEMENTS THAT YOU TAKE:

_____

_____

_____

_____

*Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

| | Yes | No | DK |
|---|---|---|---|
| Heart murmur | ☐ | ☐ | ☐ |
| Mitral valve prolapse | ☐ | ☐ | ☐ |
| Artificial heart valves | ☐ | ☐ | ☐ |
| Rheumatic fever | ☐ | ☐ | ☐ |
| Cardiovascular disease | ☐ | ☐ | ☐ |
| Angina | ☐ | ☐ | ☐ |
| Arteriosclerosis | ☐ | ☐ | ☐ |
| Congestive heart failure | ☐ | ☐ | ☐ |
| Coronary artery disease | ☐ | ☐ | ☐ |
| Damaged heart valves | ☐ | ☐ | ☐ |
| Heart attack | ☐ | ☐ | ☐ |
| Low blood pressure | ☐ | ☐ | ☐ |
| High blood pressure | ☐ | ☐ | ☐ |
| Congenital heart defects | ☐ | ☐ | ☐ |
| Pacemaker | ☐ | ☐ | ☐ |
| Rheumatic heart disease | ☐ | ☐ | ☐ |
| Abnormal bleeding | ☐ | ☐ | ☐ |

| | Yes | No | DK |
|---|---|---|---|
| Anemia | ☐ | ☐ | ☐ |
| Blood transfusion | ☐ | ☐ | ☐ |
| If yes, date: _____ | | | |
| Hemophilia | ☐ | ☐ | ☐ |
| AIDS or HIV infection | ☐ | ☐ | ☐ |
| Arthritis | ☐ | ☐ | ☐ |
| Autoimmune disease | ☐ | ☐ | ☐ |
| Rheumatoid arthritis | ☐ | ☐ | ☐ |
| Systemic lupus erythematosus | ☐ | ☐ | ☐ |
| Asthma | ☐ | ☐ | ☐ |
| Bronchitis | ☐ | ☐ | ☐ |
| Emphysema | ☐ | ☐ | ☐ |
| Sinus trouble | ☐ | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ | ☐ |
| Cancer/Chemotherapy/ Radiation Treatment | ☐ | ☐ | ☐ |
| Chest pain upon exertion | ☐ | ☐ | ☐ |

| | Yes | No | DK |
|---|---|---|---|
| Chronic pain | ☐ | ☐ | ☐ |
| Diabetes Type I or II | ☐ | ☐ | ☐ |
| Eating disorder | ☐ | ☐ | ☐ |
| Malnutrition | ☐ | ☐ | ☐ |
| Gastrointestinal disease | ☐ | ☐ | ☐ |
| G.E. Reflux/persistent heartburn | ☐ | ☐ | ☐ |
| Ulcers | ☐ | ☐ | ☐ |
| Thyroid problems | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ |
| Glaucoma | ☐ | ☐ | ☐ |
| Hepatitis, jaundice or liver disease | ☐ | ☐ | ☐ |
| Epilepsy | ☐ | ☐ | ☐ |
| Fainting spells or seizures | ☐ | ☐ | ☐ |
| Neurological disorders | ☐ | ☐ | ☐ |
| If yes, Specify: _____ | | | |

| | Yes | No | DK |
|---|---|---|---|
| Sleep disorder | ☐ | ☐ | ☐ |
| Mental health disorders | ☐ | ☐ | ☐ |
| Specify: _____ | | | |
| Recurrent Infections | ☐ | ☐ | ☐ |
| Type of infection: _____ | | | |
| Kidney problems | ☐ | ☐ | ☐ |
| Night sweats | ☐ | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ | ☐ |
| Persistent swollen glands in neck | ☐ | ☐ | ☐ |
| Severe headaches/ migraines | ☐ | ☐ | ☐ |
| Severe or rapid weight loss | ☐ | ☐ | ☐ |
| Sexually transmitted disease | ☐ | ☐ | ☐ |
| Excessive urination | ☐ | ☐ | ☐ |

| | Yes | No | DK |
|---|---|---|---|
| Do you use controlled substance (drugs)? | ☐ | ☐ | ☐ |
| Do you use tobacco (smoking, snuff, chew, bidis)? | ☐ | ☐ | ☐ |
| If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED | | | |
| Do you drink alcoholic beverages? | ☐ | ☐ | ☐ |
| If yes, how much alcohol did you drink in the last 24 hours? _____ | | | |
| If yes, how much do you typically drink in a week? _____ | | | |

| | Yes | No | DK |
|---|---|---|---|
| **WOMEN ONLY** Are you: | | | |
| Pregnant? | ☐ | ☐ | ☐ |
| Number of weeks: _____ | | | |
| Taking birth control pills or hormonal replacement? | ☐ | ☐ | ☐ |
| Nursing? | ☐ | ☐ | ☐ |

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐

Please explain: _____

_____

_____

_____

# Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

| | Yes | No | DK |
|---|---|---|---|
| Are you taking or scheduled to being taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? | ☐ | ☐ | ☐ |
| Since 2001, were you treated or are you presently scheduled to being treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? | ☐ | ☐ | ☐ |
| Date Treatment began: _____ | | | |
| **Joint Replacement.** Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? | ☐ | ☐ | ☐ |
| Date: _____ | | | |

| **Allergies** - Are you allergic to or have you had a reaction to: To all **yes** responses, specify type of reaction. | Yes | No | DK |
|---|---|---|---|
| Local anesthetics _____ | ☐ | ☐ | ☐ |
| Aspirin _____ | ☐ | ☐ | ☐ |
| Penicillin or other antibiotics _____ | ☐ | ☐ | ☐ |
| Barbiturates, sedatives, or sleeping pills _____ | ☐ | ☐ | ☐ |
| Sulfa drugs _____ | ☐ | ☐ | ☐ |
| Codeine or other narcotics _____ | ☐ | ☐ | ☐ |
| Other medications or substances _____ | ☐ | ☐ | ☐ |

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

I understand that my dental insurance carrier may pay less than the actual bill of services. I agree to be responsible for services as rendered on my behalf or my dependents.

**NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**
I certify that I have read and understand 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 acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member 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.

| Signature of Patient/Legal Guardian: | Date: |
|---|---|
| | |

## FOR COMPLETION BY DENTIST

Comments _____