KISKI ADVANCED DENTISTRY

Health History Form

First Name:_____ Last Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Email:_____ Date of Birth:_____ SSN:_____

Emergency Contact:_____ Phone Number:_____

Dental Information - Please check if you have any of the following:

- ☐ Bleeding Gums
- ☐ Sensitivity to hot/cold
- ☐ Dry mouth
- ☐ Have had periodontal treatments
- ☐ Have had orthodontic treatments
- ☐ Currently experiencing Dental Pain
- ☐ Ear aches or neck pain
- ☐ Clicking, popping or discomfort in the jaw
- ☐ Grind teeth
- ☐ Sores or ulcers in mouth
- ☐ Wear dentures or partials
- ☐ Serious injury to head or mouth

Medical Information Please check if you have any of the following:

Family Physician:_____ Phone Number:_____

Preferred Pharmacy:_____

Please check if you have any of the following:

Have you ever had a joint replacement? ☐ If yes, when?_____

Are you currently taking or going to start taking an antiresorptive agent? ☐ If yes, what do you take?
(like Fosamax, Actonel, Atelvia, Boniva, Reclast, and Prolia) _____

Do you use controlled substances? ☐

Do you use tobacco? ☐

Do you consume alcohol? ☐ Drinks per week:_____

WOMEN ONLY

Are you currently pregnant? ☐ Number of weeks:_____

Are you Nursing? ☐

Are you taking birth control pills/hormone replacement? ☐

Allergies - Please Check if you have any allergies to the following:

Local anesthetics	☐	Metals	☐
Aspirin	☐	Latex	☐
Penicillin	☐	Iodine	☐
Barbiturates, sedatives or sleeping pills	☐	Hay fever/seasonal	☐
Sulfa drugs	☐	Animals	☐
Codeine	☐	Food	☐

Other Allergies:_____

Medications

Please list all medications that you are taking or provide us with a medication list:

_____

_____

Medical History - Please check if you have been diagnosed with the following:

Cardiovascular disease	☐	Asthma	☐
Angina	☐	Bronchitis	☐
Arteriosclerosis	☐	Emphysema	☐
Congestive heart failure	☐	Sinus trouble	☐
Damaged heart valves	☐	Tuberculosis	☐
Heart attack	☐	Cancer/Chemo/Radiation	☐
Heart murmur	☐	Chest pain	☐
Low blood pressure	☐	Chronic pain	☐
High blood pressure	☐	Diabetes	☐
Mitral valve prolapse	☐	Eating disorder	☐
Pacemaker/Defibrillator	☐	Gastrointestinal disease	☐
Rheumatic fever	☐	Acid reflux/Heartburn	☐
Abnormal bleeding	☐	Ulcers	☐
Anemia	☐	Thyroid problems	☐
Blood transfusion	☐	Stroke	☐
Hemophilia	☐	Hepatitis/Jaundice/Liver disease	☐
AIDS or HIV	☐	Rapid weight loss	☐
Herpes	☐	Epilepsy	☐
Arthritis	☐	Fainting	☐
Autoimmune disease	☐	Neurologic disorders	☐
Rheumatoid arthritis	☐	Sleep disorders	☐
Lupus	☐	Mental health disorders	☐
Recurrent infections	☐	Kidney problems	☐
Osteoporosis	☐	Severe headaches/Migraines	☐
STDs	☐	Excessive urination	☐

Please list any condition not listed above: _____

Patient/Guardian Signature:_____ Date:_____

Signature of Dentist:_____ Date:_____