RATHDRUM DENTAL
DR. JEFFREY L. OSWELL, D.M.D.

# Health History Form

Name: Last_____ First_____ MI___
Home Phone: (  )_____ Cell Phone: (  )_____ Email:_____
Address: Mailing:_____ City:_____ State:___ Zip:_____
Date of Birth:_____ Sex: M_____ F_____ SS #_____
Emergency Contact:_____ Relationship:_____ Phone:(  )_____
If you are completing this form for another person, what is your relationship to that person?
Your Name:_____ Relationship:_____

**Do you have any of the following diseases or problems: Please check all that apply.**

- Active Tuberculosis
- Persistent cough greater than a 3 week duration
- Cough that produces blood
- Been exposed to anyone with Tuberculosis

**Dental Information: Please check all that apply.**

- Do your gums bleed when you brush or floss?
- Are your teeth sensitive to cold, hot, sweets or pressur
- Does food or floss catch between your teeth?
- Is your mouth dry?
- Have you had any periodontal treatments?
- Have you ever had orthodontic treatments?
- Do you have earaches or neck pain?
- Do you have any clicking, popping or discomfort in the jaw?
- Do you brux or grind your teeth?
- Do you have sore or ulcers in your mouth?
- Do you wear dentures or partials?
- Have you ever had a serious injury to your head or mouth?

What is the reason for your dental visit today? _____
Are you currently experiencing dental pain or discomfort? _____
Have you experienced problems or anxiety with previous dental treatment? _____
Date of your last dental Exam: _____ Date of last dental x-rays: _____

**Medical Information: Please check all that apply.**

- Are you now under the care of a physician?
  Physician Name: _____ Phone: (  )_____
- Has there been any change in your general health within the past year?
  If yes, what condition is being treated? _____
- Have you had a serious illness, operation or been hospitalized in the past 5 years?
  If yes, what was the illness or problem? _____
- Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment?
- Are you taking or have you recently taken any prescription or over the counter medicine(s)?
  If so, please list **all,** including vitamins, natural or herbal preparations and/or diet supplements:

_____
_____
_____

_____

_____

**Allergies: Please check all that apply and specify the type of reaction. If none apply, please write none.**

- Local anesthetics _____
- Aspirin _____
- Antibiotics _____
- Barbiturates, sedatives, sleeping pills _____
- Metals _____
- Sulfa Drugs _____
- Codeine or other narcotics _____
- Other _____

- Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenlluramine-phentermine combination)?
- Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for Osteoporosis or Paget's disease?
- Since 2003, were you treated or are you presently scheduled to begin 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: _____

- Do you use controlled substances?
- Do you use tobacco (smoking, snuff, chew, bidis)?

  If so, how interested are you in stopping? (Check one Very _____ Somewhat _____ Not Interested _____
- Do you drink alcoholic beverages?

**Women Only:** Are you:

- Pregnant? If so, number of weeks: _____
- Taking birth control pills or hormonal replacement?
- Nursing?

normal

**Joint Replacement:**

- Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

Date: _____

**Please check all that apply: If none apply, please write none.**

- 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
- Anemia
- Hemophilia
- Aids or HIV Infection
- Arthritis
- Bronchitis
- Emphysema
- Sinus Trouble
- Tuberculosis
- Cancer/ Chemotherapy/ Radiation Treatment
- Chest Pain upon Exertion
- Chronic Pain
- Diabetes Type I or II
- Eating Disorder
- Malnutrition
- Gastrointestinal Disease
- G.E Reflux/ Heartburn
- Ulcers
- Thyroid Disease
- Stroke
- Blood Transfusion
- Glaucoma
- Hepatitis, Jaundice or Liver Disease
- Epilepsy
- Fainting or Seizures
- Neurological Disorders
  Specify: _____
- Sleep Disorder
- Mental Health Disorders
  Specify _____
- Recurrent Infections
- Kidney Problems
- Night Sweats
- Osteoporosis
- Persistent Swollen Glands in Neck
- Severe Headaches or Migraines
- Severe or Rapid Weight Loss
- Excessive Urination
- Other

Date: _____

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 inquiries 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 have made in the completion of this form. I understand that it is my responsibility to inform the dental office of any changes to my medical status. I also understand that I assume responsibility for fees associated with procedures and services.

**Patient (Parent, Guardian) Signature**: _____ **Date:** _____