Beach Smile Dental
Redondo Beach, CA
Family Dentistry • Aesthetic Dentistry
Implants Dentistry

Name	Date of Birth	Page 1

HEALTH HISTORY QUESTIONNAIRE (CONFIDENTIAL)

1. Have you had any health problems in the past five (5) years? ..... Yes No
2. Have you seen a physician or other health care provider in the past two (2) years? ..... Yes No
   Physician's name: _____ Phone # or City: _____
3. Is there any activity your doctor says you cannot do? ..... Yes No
4. Have you been hospitalized or had a serious illness in the past (5) years? ..... Yes No
5. Have you ever had a bleeding problem? ..... Yes No

Vital Signs	B.P. / Pulse	B.P. / Pulse	B.P. / Pulse	B.P. / Pulse	B.P. / Pulse	B.P. / Pulse	B.P. / Pulse	B.P. / Pulse
Date								

Please circle the appropriate response if you have ever had the following. If you are not sure, do not answer the question.

HEART/BLOOD VESSELS

Rheumatic Fever ..... Yes No
Rheumatic Heart Disease ..... Yes No
Heart Valve Damage ..... Yes No
Heart Murmur ..... Yes No
Congenital Heart Defect ..... Yes No
Artificial Heart Valve ..... Yes No
Prolapsed Heart Valve ..... Yes No
High Blood Pressure…….. Yes No
Heart Attack (Date_____)……Yes No
TIA/Stroke (Date_____)…… Yes No
Heart Surgery (Date_____) .Yes No
Vascular Surgery (Date_____) . Yes No
Pacemaker……..Yes No
Coronary Heart Disease…….. Yes No
Congestive Heart Failure…… Yes No
Angina Pectoris/Chest Pain…… Yes No
Irregular/Rapid Heart Beats…… Yes No
Other Heart or Vessel Disorder……..Yes No

BLOOD

Blood Clots or Thrombosis ..... Yes No
Anemia ..... Yes No
Sickle Cell Disease/Trait……. Yes No
Hemophilia ..... Yes No
Transfusion (Date_____) ..... Yes No
Bruise easily for no apparent reason…… Yes No
Other Blood Disorder ..... Yes No

NERVOUS SYSTEM

Epilepsy…….. Yes No
Seizure Disorder…….. Yes No
Multiple Sclerosis…… Yes No
Trigeminal Neuralgia……..Yes No
Chronic Pain…… Yes No
Anxiety/Depression…… Yes No
Alzheimer's Disease/Dementia…….. Yes No
Psychiatric Treatment…….. Yes No
Psychological Counseling…….. Yes No
Persistent Dizziness/Fainting Spells…….. Yes No
Persistent Numbness/Tingling……Yes No
Other Nervous/Mental Disorder……..Yes No

HEAD AND NECK

Glaucoma……Yes No
Chronic Sinusitis……Yes No
Injury to Head, Neck, Jaw or Teeth ..... Yes No
Headaches ..... Yes No
Unexplained Visual Change ..... Yes No
Frequent or Severe Nosebleeds…….. Yes No
Persistent Sore Throat or Hoarseness…….. Yes No
Recurrent Neckache or Neck Pain……Yes No
Recent Difficulty Swallowing…….. .Yes No
Other Head or Neck Disorder…….. Yes No

ENDOCRINE

Diabetes…….. Yes No
Low Thyroid…… Yes No
Other Thyroid Condition…… Yes No
Cushings Syndrome……Yes No
Parathyroid Condition…… Yes No
Other Endocrine Condition……..Yes No

MUSCULOSKELETAL/CONNECTIVE TISSUE

Sjögren's Syndrome…… ……Yes No
Arthritis…… ……Yes No
Artificial Joint (Date_____Yes No
Fibromyalgia/Rheumatism…….. Yes No
Chronic Back Pain…….. Yes No
Other Muscle or Bone Disorder……Yes No

RESPIRATORY

Tuberculosis (TB)…… ……Yes No
Asthma…… .Yes No
Chronic Bronchitis…… ……...Yes No
Emphysema…… ……. Yes No
Persistent Cough…… ……..Yes No
Cough Up Bloody Sputum…….. Yes No
Shortness of Breath…… Yes No
Sleep apnea ..... Yes No
Other Respiratory Disorder…… Yes No

URINARY TRACT

Kidney Disease ..... Yes No
Renal Dialysis ..... Yes No
Venereal Disease ..... Yes No
Sexually Transmitted Disease ..... Yes No
Other Urinary Disorder ..... Yes No

DIGESTIVE SYSTEM

Hepatitis ..... Yes No
Cirrhosis of the Liver/Liver Disease ..... Yes No
Ulcers ..... Yes No
Jaundice ..... Yes No
Frequent Heartburn or Reflux ..... Yes No
Frequent Nausea/Vomiting ..... Yes No
Other Digestive Disorder ..... Yes No

CANCER HISTORY

Cancer ..... Yes No
If yes, what type
Leukemia ..... Yes No
Benign Tumors/Growths ..... Yes No
Type of Treatment:
Surgery ..... Yes No
Radiation Therapy ..... Yes No
Chemotherapy ..... Yes No
Hormone Therapy ..... Yes No
IV bisphosphonates (i.e.Zometa or Aredia) ..... Yes No

ALLERGY HISTORY

Are you allergic to or have you ever had a bad reaction to any of the following?
Dental Anesthetics ..... Yes No
Penicillin ..... Yes No
Sulfa Drugs ..... Yes No
Other Antibiotics ..... Yes No
Aspirin ..... Yes No
Latex Products ..... Yes No
Metals, including Jewelry ..... Yes No
Other Allergy ..... Yes No

FAMILY HISTORY

Has anyone in your family (grandparent, parent, sibling, child) ever had:
Diabetes ..... Yes No
Heart Disease ..... Yes No
Depression or Anxiety ..... Yes No
Tuberculosis ..... Yes No
Any disorder that "runs in" your family ..... Yes No

PLEASE CONTINUE ON OTHER SIDE

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HEALTH HISTORY QUESTIONNAIRE (continued)

Please circle "yes" if you have ever had the following. If you are not sure, do not answer the question.

MISCELLANEOUS

Lupus Erythematosus.....Yes No
Organ Transplant.....Yes No
If yes, which organ? _____
Suppressed Immune System.....Yes No
Persistent Fever.....Yes No
Taken Steroid/Prednisone .....Yes No
Taken Prescription Diet Pills.....Yes No
If yes, please check type:
D Pondimin D Phen-fen
D Redux D Other_____

MISCELLANEOUS (CONTINUED)

Used Tobacco Products……. Yes No
If yes, what type?
How much?_____ How long? _____
Still using tobacco?.....Yes No
Would you like to quit?..... Yes No
Quit on? (Date_____)
Drink alcoholic beverages?..... Yes No
If yes, how much?
Used Methamphetamine, Amphetamines or "Speed"…….. Yes No
Used Intravenous Drugs…… Yes No
Used Cocaine or "Crack"…….. Yes No

MISCELLANEOUS (CONTINUED)

Used any other recreational drugs ..... Yes No
Are you a recovering alcoholic or addict?..... Yes No

WOMEN ONLY

Are you taking birth control pills..... Yes No
Are you pregnant or is there a possibility that you may be pregnant?..... Yes No
If yes, due date? _____
Are you breast feeding?..... Yes No
Are you in or have you passed through Menopause (change of life)?..... Yes No

Do you have any other condition that you think we should know about? D Yes D No _____

_____

Please circle all the medications you are currently taking:

Heart	Blood Thinners	Hormones	Antibiotics	Tranquilizers
Nitroglycerin	Blood Pressure	Insulin/Diabetic Drugs	Antihistamine	Antidepressants
Digitalis	Oral Contraceptive	Thyroid	Cyclosporine A	Pain
Aspirin (_____tabs/day)	Steroids/Cortisone	Nifedipine		

List medication names and dosages; include over-the-counter, herbal, and nutritional supplements:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

_____

Signature of Patient, Parent or Guardian Date

HEALTH/ MEDICATION UPDATES

Date	Note changes below	Patient Signature

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DENTAL HISTORY

Reason for this visit _____

When was your last dental visit? _____ What was done then? _____

How often did you visit the dentist before then? _____

Previous dentist? (Name and Location) _____

Have you had a complete series of dental films (x-rays) taken? When? Where? _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Is your drinking water fluoridated? _____

If you could change anything about your smile, what would you change? _____

Do your gums bleed while brushing or flossing..... Yes No

Are your teeth sensitive to hot or cold liquids/ foods..... Yes No

Are your teeth sensitive to sweet or sour liquids/ foods..... Yes No

Do you feel pain to any of your teeth ... Yes No

Do you have any sores or lumps in or near your mouth ..... Yes No

Have you had any head, neck or jaw injuries ..... Yes No

Do you have frequent headaches ..... Yes No

Have you ever experienced any of the following problems in your jaw?

Clicking..... Yes No

Pain (joint, ear, side of face) ..... Yes No

Difficulty in opening or closing ..... Yes No

Difficulty in chewing ..... Yes No

Do you clench or grind your teeth..... Yes No

Do you bite your lips or cheeks frequently ..... Yes No

Have you noticed any loosening of your teeth. ..... Yes No

Does food tend to become caught between your teeth..... Yes No

Have you ever had periodontal treatment (gums) ..... Yes No

Have you ever worn a bite plate or appliance..... Yes No

Have you ever had any difficult extractions in the past..... Yes No

Have you ever had any prolonged bleeding following extractions..... Yes No

Do you wear dentures or partials.. Yes No
If yes, date of placement _____

Have you ever received oral hygiene instructions regarding the care of your teeth and gums..... Yes No

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____

Signature of Patient, Parent or Guardian Date

ADDITIONAL NOTES