



# Hamann Family Dentistry's Health History Form

## Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_  Male  Female  Married  Single  Child  
Social Security Number: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ (Cell): \_\_\_\_\_  
Address: \_\_\_\_\_  
Street Apt. #  
City State Zip code

## Referral Information

Whom may we thank for referring you to our practice?

Another patient, friend: \_\_\_\_\_  Another patient, relative: \_\_\_\_\_  
 Yellow Pages/Phone Book  Newspaper  Work  Website  Insurance  Location  
 Employee of Hamann Family Dentistry: \_\_\_\_\_  Other: \_\_\_\_\_

## Employment Information

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

## Emergency Contact Information

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Phone: \_\_\_\_\_

## Health Information

Date of Last Dental Visit: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

Have you ever had any of the following? Please check those that apply:

- AIDS
- Allergies
- Codeine
- Penicillin
- Local Anesthetic
- Sulfa Drug
- Metals
- Other: \_\_\_\_\_
- Abnormal Bleeding
- Anemia
- Arthritis
- Artificial Joints
- Asthma
- Blood Disease
- Cancer
- Chemotherapy
- Diabetes
- Type I
- Type II
- Dizziness
- Eating Disorder
- Epilepsy
- Excessive Bleeding
- Fainting
- G.E. Reflux
- Glaucoma
- Growths
- Hay Fever
- Head Injuries
- Heart Attack
- Heart Disease
- Heart Murmur
- Hepatitis
- High Blood Pressure
- Jaundice
- Kidney Disease
- Liver Disease
- Mental Disorders
- Nervous Disorders
- Osteoporosis
- Pace Maker
- Pregnancy
- Due Date: \_\_\_\_\_
- Radiation Treatment
- Respiratory Problems
- Rheumatism
- Seizures/Fainting Spells
- Sinus Problems
- Stomach problems
- Stroke
- Tuberculosis
- Tumors
- Ulcers
- Venereal Disease
- Other: \_\_\_\_\_

Have you ever had complications following a dental treatment?  Yes  No  
If yes, please explain: \_\_\_\_\_

Are you under the care of a physician?  Yes  No  
If yes, physician's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you been admitted to a hospital or needed emergency care during the past two year?  Yes  No  
If yes, please explain: \_\_\_\_\_

Have you had an orthopedic total joint (hip, knee, elbow) replacement?  Yes  No  
If yes, any complications? \_\_\_\_\_ Date: \_\_\_\_\_

Are you taking or schedule to take either alendronate (Fosamax) or risedronate (Actonel) for osteoporosis?  
 Yes  No

Are you taking or presently schedules to begin treatment with the intravenous bisphosphonates (Aredia or Zometa)?  
 Yes, date treatment began: \_\_\_\_\_  No

Are you currently taking any medication that is a blood thinner?  Yes  No  
Name of Medication: \_\_\_\_\_ Start Date: \_\_\_\_\_

Do you have any health problems that need further clarification?  Yes  No  
If yes, please explain: \_\_\_\_\_

Do you smoke?  Yes  No                      Do you chew tobacco?  Yes  No

I certify that I have read and understood 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 will not hold my dentist, or any other members 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. If changes in my health, I will inform the doctors.

Signature of patient: \_\_\_\_\_ Date: \_\_\_\_\_