HEALTH HISTORY FORM

Jill Kollar DMD Professional LLC | d/b/a Precision Dental of Windsor

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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.

Today's Date: _____ Email: _____

Patient information

Name (Last, First, Middle): _____ Home Phone: _____

Cell Phone: _____ Address (Mailing): _____

City: _____ State: _____ Zip: _____ Occupation: _____

Weight: _____ Date of Birth: _____ Sex: ☐ M ☐ F SS# or Patient ID: _____

Height: _____ Emergency Contact: _____ Relationship: _____

Emergency Contact Home Phone: _____ Cell Phone: _____

If you are completing this form for another person, your name: _____

Your relationship to that person: _____

MEDICAL ALERTS: ANTIBIOTIC PREMEDICATION AND INFECTIVE ENDOCARDITIS

Please check any of the following that apply to you. These heart conditions may require antibiotics before dental treatment.

☐ Artificial (prosthetic) heart valve
☐ Previous infective endocarditis
☐ Damaged valves in a transplanted heart
☐ Congenital heart disease (CHD): unrepaired, cyanotic CHD
☐ Congenital heart disease: repaired (completely) in the last 6 months
☐ Congenital heart disease: repaired CHD with residual defects

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of congenital heart disease.

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ Yes ☐ No ☐ DK

Name of physician or dentist making recommendation: _____ Phone: _____

Tuberculosis screening

Do you have any of the following diseases or problems? (Check DK if you don't know the answer.)

Active tuberculosis
☐Y ☐N ☐DK

Persistent cough greater than a 3 week duration
☐Y ☐N ☐DK

Cough that produces blood
☐Y ☐N ☐DK

Been exposed to anyone with tuberculosis
☐Y ☐N ☐DK

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental information

Do your gums bleed when you brush or floss?
☐Y ☐N ☐DK

Are your teeth sensitive to cold, hot, sweets or pressure?
☐Y ☐N ☐DK

Is your mouth dry?
☐Y ☐N ☐DK

Have you had any periodontal (gum) treatments?
☐Y ☐N ☐DK

Have you ever had orthodontic (braces) treatment?
☐Y ☐N ☐DK

Are you currently experiencing dental pain or discomfort?
☐Y ☐N ☐DK

Do you have earaches or neck pains?
☐Y ☐N ☐DK

Do you have any clicking, popping or discomfort in the jaw?
☐Y ☐N ☐DK

Do you brux or grind your teeth?
☐Y ☐N ☐DK

Do you have sores or ulcers in your mouth?
☐Y ☐N ☐DK

Have you had any problems associated with previous dental treatment?
☐Y ☐N ☐DK

Is your home water supply fluoridated?
☐Y ☐N ☐DK

Do you drink bottled or filtered water? If yes, how often? (Circle one: DAILY / WEEKLY / OCCASIONALLY)
☐Y ☐N ☐DK

Do you wear dentures or partials?
☐Y ☐N ☐DK

Do you participate in active recreational activities?
☐Y ☐N ☐DK

Have you ever had a serious injury to your head or mouth?
☐Y ☐N ☐DK

Date of your last dental exam: _____ What was done at that time? _____

Date of last dental x-rays: _____ Reason for your dental visit today: _____

How do you feel about your smile? _____

Medical information

Are you now under the care of a physician? ☐ Yes ☐ No ☐ DK

Physician Name: _____ Phone: _____

Physician Address/City/State/Zip: _____

Are you in good health? ☐ Yes ☐ No ☐ DK

Has there been any change in your general health within the past year? If yes, what condition is being treated? _____ ☐ Yes ☐ No ☐ DK

Date of last physical exam: _____

Have you had a serious illness, operation or been hospitalized in the past 5 years? If yes, what was the illness or problem? _____ ☐ Yes ☐ No ☐ DK

Are you taking or have you recently taken any prescription or over the counter medicine(s)? ☐ Yes ☐ No ☐ DK

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

1. _____ 2. _____ 3. _____ 4. _____

Are you taking a GLP-1 medication (such as Ozempic, Wegovy, Mounjaro, or Rybelsus)? If yes, which one? _____ ☐ Yes ☐ No ☐ DK

Do you wear contact lenses? ☐ Yes ☐ No ☐ DK

Joint replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Date: _____ If yes, have you had any complications? _____ ☐ Yes ☐ No ☐ DK

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for osteoporosis or Paget's disease? ☐ Yes ☐ No ☐ DK

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Date treatment began: _____ ☐ Yes ☐ No ☐ DK

Do you use controlled substances (drugs)? ☐ Yes ☐ No ☐ DK

Do you use tobacco (smoking, snuff, chew, bidis)? If so, how interested are you in stopping? (Circle one: VERY / SOMEWHAT / NOT INTERESTED) ☐ Yes ☐ No ☐ DK

Do you drink alcoholic beverages? If yes, how much in the last 24 hours? _____ How much do you typically drink in a week? _____ ☐ Yes ☐ No ☐ DK

Women only: Are you pregnant? ☐ Yes ☐ No ☐ DK Number of weeks: _____ Taking birth control pills or hormonal replacements? ☐ Yes ☐ No ☐ DK Nursing? ☐ Yes ☐ No ☐ DK

Allergies

Are you allergic to or have you had a reaction to any of the following? To all yes responses, specify the type of reaction.

Local anesthetics
☐Y ☐N ☐DK

Barbiturates, sedatives, or sleeping pills
☐Y ☐N ☐DK

Metals
☐Y ☐N ☐DK

Hay fever/seasonal
☐Y ☐N ☐DK

Other
☐Y ☐N ☐DK

Aspirin
☐Y ☐N ☐DK

Sulfa drugs
☐Y ☐N ☐DK

Latex (rubber)
☐Y ☐N ☐DK

Animals
☐Y ☐N ☐DK

Reaction(s):

Penicillin or other antibiotics
☐Y ☐N ☐DK

Codeine or other narcotics
☐Y ☐N ☐DK

Iodine
☐Y ☐N ☐DK

Food
☐Y ☐N ☐DK

_____

Medical conditions

Please mark whether you have or have not had any of the following diseases or problems.

Cardiovascular disease
☐Y ☐N ☐DK
Angina
☐Y ☐N ☐DK
Arteriosclerosis
☐Y ☐N ☐DK
Congestive heart failure
☐Y ☐N ☐DK
Damaged heart valves
☐Y ☐N ☐DK
Heart attack
☐Y ☐N ☐DK
Heart murmur
☐Y ☐N ☐DK
Low blood pressure
☐Y ☐N ☐DK
High blood pressure
☐Y ☐N ☐DK
Other congenital heart defects
☐Y ☐N ☐DK

Mitral valve prolapse
☐Y ☐N ☐DK
Pacemaker
☐Y ☐N ☐DK
Rheumatic fever
☐Y ☐N ☐DK
Rheumatic heart disease
☐Y ☐N ☐DK
Abnormal bleeding
☐Y ☐N ☐DK
Anemia
☐Y ☐N ☐DK
Blood transfusion (date: _____)
☐Y ☐N ☐DK
Hemophilia
☐Y ☐N ☐DK
AIDS or HIV infection
☐Y ☐N ☐DK

Arthritis
☐Y ☐N ☐DK
Autoimmune disease
☐Y ☐N ☐DK
Rheumatoid arthritis
☐Y ☐N ☐DK
Systemic lupus erythematosus
☐Y ☐N ☐DK
Asthma
☐Y ☐N ☐DK
Bronchitis
☐Y ☐N ☐DK
Emphysema
☐Y ☐N ☐DK
Sinus trouble
☐Y ☐N ☐DK
Tuberculosis
☐Y ☐N ☐DK
Cancer / chemotherapy / radiation (specify: _____)
☐Y ☐N ☐DK
Chest pain upon exertion
☐Y ☐N ☐DK
Chronic pain
☐Y ☐N ☐DK
Diabetes Type I or II
☐Y ☐N ☐DK
Eating disorder
☐Y ☐N ☐DK
Malnutrition
☐Y ☐N ☐DK
Gastrointestinal disease
☐Y ☐N ☐DK
G.E. reflux / persistent heartburn
☐Y ☐N ☐DK
Ulcers
☐Y ☐N ☐DK
Thyroid problems
☐Y ☐N ☐DK

Stroke
☐Y ☐N ☐DK
Excessive urination
☐Y ☐N ☐DK
Glaucoma
☐Y ☐N ☐DK
Hepatitis, jaundice or liver disease
☐Y ☐N ☐DK
Epilepsy
☐Y ☐N ☐DK
Fainting spells or seizures
☐Y ☐N ☐DK
Neurological disorders (specify: _____)
☐Y ☐N ☐DK
Sleep disorder
☐Y ☐N ☐DK
Do you snore?
☐Y ☐N ☐DK
Mental health disorders, such as depression or anxiety (specify: _____)
☐Y ☐N ☐DK
Recurrent infections (type: _____)
☐Y ☐N ☐DK
Kidney problems
☐Y ☐N ☐DK
Night sweats
☐Y ☐N ☐DK
Osteoporosis
☐Y ☐N ☐DK
Persistent swollen glands in neck
☐Y ☐N ☐DK
Severe headaches / migraines
☐Y ☐N ☐DK
Severe or rapid weight loss
☐Y ☐N ☐DK
Sexually transmitted disease
☐Y ☐N ☐DK

Do you have any disease, condition, or problem not listed above that you think we should know about? Please explain:
_____ ☐ Yes ☐ No ☐ DK

Certification

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 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 may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____

FOR COMPLETION BY DENTIST Comments: _____

_____