D. Jack Fong, D.D.S.
amarillo craniofacial pain diagnostic center

American Dental Association Health History

Date _____

Name _____ Address: _____
City/State/Zip _____ Phone _____
Occupation _____ Business Phone _____
Date of Birth _____ Sex: M F Height _____ Weight _____
Nearest Relative _____ Phone _____
If you are completing this form for another person, what is your relationship to that person? _____

For the following questions, **CIRCLE YES OR NO,** whichever applies. Your answers are for our records only and are CONFIDENTIAL. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. **THANK YOU!**

1. Are you in good health? ..... Yes No
2. Has there been any change in your general health within the past year? ..... Yes No
3. My last physical examination was on _____
4. Are you now under the care of a physician or alternative healthcare provider? ..... Yes No
5. Name of my physician _____
6. Have you or are you taking any of the following? Fosamax/Fosamax D, Didronel, Boniva, Actonel, Skelid, Aredia, Zometa, Bonefos? ..... Yes No
7. Are you taking any medicine(s) including non prescriptions, homeopathics, vitamins, and herbs? ..... Yes No
   If so, please list all medications, non prescriptions, homeopathics, vitamins, and herbs:
   _____ _____
   _____ _____
   _____ _____
8. Do you have or have you had any of the following diseases or problems?
   a) Rheumatic fever or rheumatic heart disease? ..... Yes No
   b) Cardiovascular disease – please circle (heart trouble, heart attack, coronary occlusion, arteriosclerosis, stroke, mitral valve prolapse, heart murmur? Yes No
      1) Do you have pain in the chest upon exertion? ..... Yes No
      2) Are you ever short of breath after mild exercise? ..... Yes No
      3) Do your ankles swell? ..... Yes No
      4) Do you get short of breath when you lie down, or do you require extra pillows to sleep? ..... Yes No
      5) Do you have a cardiac pacemaker? ..... Yes No
   c) Allergies? ..... Yes No
   d) Sinus trouble? ..... Yes No
   e) Asthma or hay fever? ..... Yes No
   f) Hives or a skin rash? ..... Yes No
   g) Fainting spells or seizures? ..... Yes No
   h) Diabetes? ..... Yes No
      1) Do you have excessive thirst or urination? ..... Yes No
      2) Does your mouth frequently become dry? ..... Yes No
   i) Hepatitis? ..... Yes No
   j) AIDS or HIV infection? ..... Yes No
   k) Respiratory problems, emphysema, bronchitis, etc? ..... Yes No
   l) Arthritis or painful/swollen joints? ..... Yes No
   m) Stomach ulcer or hyper acidity? ..... Yes No
   n) Kidney trouble? ..... Yes No
   o) Tuberculosis? ..... Yes No
   p) Persistent cough or cough that produces blood? ..... Yes No
   q) Persistent swollen glands in your neck? ..... Yes No
   r) Low or high blood pressure (if yes, circle which one) ..... Yes No
   s) Sexually transmitted diseases? ..... Yes No

s) Epilepsy or other neurological disease? ..... Yes No
t) Problems with mental health? ..... Yes No
u) Cancer? ..... Yes No
v) Problems with the immune system? ..... Yes No

9. Have you had abnormal bleeding or required a blood transfusion? ..... Yes No
10. Do you have any blood disorder such as anemia? ..... Yes No
11. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your head or neck? ..... Yes No
12. Are you taking any of the following?

a)	Antibiotics or sulfa drugs?	Yes	No	g)	Aspirin	Yes	No
b)	Anticoagulants (blood thinners)	Yes	No	h)	Iodine	Yes	No
c)	High blood pressure medication	Yes	No	I)	Heart Medication.....	Yes	No
d)	Cortisone (steroids)	Yes	No	j)	Nitroglycerin	Yes	No
e)	Tranquilizers	Yes	No	k)	Hormonal therapy.....	Yes	No
f)	Antihistamines	Yes	No	l)	Vitamins, Herbs.....	Yes	No

13. Are you allergic to or have you reacted adversely to:

a)	Local anesthetics	Yes	No	e)	Aspirin	Yes	No
b)	Penicillin/antibiotics	Yes	No	f)	Iodine	Yes	No
c)	Sulfa Drugs	Yes	No	g)	Codeine/Narcotics.....	Yes	No
d)	Barbiturates/Sleeping Pills	Yes	No	h)	Latex	Yes	No

14. Do you smoke or use smokeless tobacco? ..... Yes No
15. Have you been told you need to be premedicated before dental treatment? ..... Yes No
16. Do you have artificial implants or a joint replacement in your body? ..... Yes No
17. Have you had any serious trouble associated with any previous dental treatment? ..... Yes No
18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? ..... Yes No
19. Are you wearing contact lenses? ..... Yes No
20. Do you have skin reactions to any metal and/or jewelry? ..... Yes No

Women:

21. Are you pregnant? ..... Yes No
22. Do you have problems associated with your menstrual period? ..... Yes No
23. Are you nursing? ..... Yes No
24. Are you taking birth control pills? ..... Yes No

Chief Dental Complaint (please be specific):

American Dental Association Early Warning Signs of Periodontal Disease

Do your gums bleed when you brush your teeth?..... Yes No
Are your gums swollen or tender? ..... Yes No
Are there gums that have pulled away from the teeth? ..... Yes No
Are there any changes in the way your teeth fit when biting? ..... Yes No
Are there permanent teeth that are loose or separating? ..... Yes No
Is there any change in the fit of your partial denture? ..... Yes No
Have you ever had periodontal disease or gum surgery? ..... Yes No

Do you have any concerns about the appearance of your teeth?..... Yes No
Do you have any concerns about the position of your teeth? ..... Yes No
Do you have concerns about the shape of your teeth? ..... Yes No
Do you have concerns about the color or shade of your teeth? ..... Yes No

Early Warning Signs of Temporomandibular Joint Disease

Do you have chronic headaches? ..... Yes No
Do you have chronic neck pain or stiffness? ..... Yes No
Do you have ringing, buzzing or clogged ears? ..... Yes No
Do you have pain in the ears or face? ..... Yes No
Do you have clicking or grinding noises in your jaw joints? ..... Yes No
Do you grind, clench or brux your teeth? ..... Yes No
Do you chew on only one side of your mouth? Which one? Right Left ..... Yes No
Do your teeth or jaws ever feel “tired” when you wake up? ..... Yes No

I certify that I have read and understand the above. I acknowledge that my questions, if any about the inquires 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 errors or omissions that I may have made in the completion of this form.

_____

Signature of Patient or Parent if under 18 years old

Any other comments about your health and or teeth you would like us to know: