DENTAL CLINIQUE
1420 N Arlington Heights Rd, Ste.130
Arlington Heights, IL 60004
847 – 392 - 6610

Health History Form – Update

Name ________________________________ Date _________________

Email ________________________________

Do you have a new address or phone number? Y N ____

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Do you have dental insurance? Y N

Has it changed in the past 6 months? Y N

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
Does food or floss catch between your teeth?	Y	N	DK
Is your mouth dry?	Y	N	DK
Are you currently experiencing dental pain, earaches or neck pain?	Y	N	DK
Do you brux or grind your teeth? TMJ issues?	Y	N	DK
Do you have sores or ulcers in your mouth?	Y	N	DK
Do you wear dentures or partials?	Y	N	DK
Have you had a serious injury to your head or mouth in the past 6 months?	Y	N	DK

- Have you experienced any unilateral ear pain?
- Difficulty swallowing or feeling as if something is stuck in their throat?
- Persistent cough, hoarseness or change in voice?
- Any sore that is not healing?
- Any swollen lymph node, gland or mass in the head & neck region?

Medical Information

Have there been any changes in your health or have you been hospitalized in the past 6 months? Y N
If yes, please describe ____

New medications

Are you required to premedicate prior to dental appointments? Y N
If yes, what is the condition that you need to premedicate for?

Have you taken Fosamax, Actonel, Aredia or Zometa ? Y N

Do you take **blood thinners**?	Y	N	INR =
Do you have **High Blood Pressure**?	Y	N	
Do you have **Diabetes**?	Y	N	Morning Glucose = HbA1C =
Do you use **tobacco**?	Y	N	
Do you drink **alcoholic beverages**?	Y	N	

Women ONLY
Are you pregnant? Y N
Number of weeks ___________________________
Taking birth control pills or hormonal replacement? Y N

Allergies ____

New medications ____

Do you have any disease, condition, problem that you think I should know about?

Please explain ____

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 her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of 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.

Signature or Patient/ Legal Guardian Date