JOHN FONDER D.M.D.
MIDTOWN DENTAL ARTS

1444 S Norfolk Ave • Tulsa OK 74120-5611

HEALTH HISTORY

E-Mail:_____

Today's Date:_____

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.

Name: Last_____First_____ Middle_____

Home Phone : ( )_____Business/Cell Phone:( )_____

Address:_____

City/Stat/Zip_____

Employer _____ Occupation _____

SS# or Patient ID_____ Height: _____ Weight: _____ Date of birth _____Sex: M F

Emergency Contact _____ Relationship _____

Home Phone( )_____Cell Phone ( ) _____

If you are completing this form for another person, what is your relationship to that person?

Your Name _____ Relationship _____

DENTAL INSURANCE

Insurance Company_____Address _____

City/State/Zip_____ Phone (_____) _____

Insured's employer _____Insured's name _____

Insured's S.S._____Relationship to patient_____

Policy number _____Insured's birthdate _____/_____/_____

Do you have secondary insurance? ❒ Yes ❒ No ❒ DK

Do you have any of the following diseases or problems: **(Check DK if you Don't Know the answer to the question)**

	Yes	No	DK
Active Tuberculosis	❒	❒	❒
Persistent cough greater than a 3 week duration	❒	❒	❒
Cough that produces blood	❒	❒	❒
Been exposed to anyone with tuberculosis	❒	❒	❒

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

DENTAL INFORMATION **For the following questions, please mark (X) your responses to the following questions.**

	Yes	No	DK
Do your gums bleed when you brush or floss?	❒	❒	❒
Are your teeth sensitive to cold, hot, sweets or pressure?	❒	❒	❒
Does food or floss catch between your teeth?	❒	❒	❒
Is your mouth dry?	❒	❒	❒
Have you had any periodontal (gum) treatments?	❒	❒	❒
Have you ever had orthodontic (braces) treatment?	❒	❒	❒
Have you had any problems associated with previous dental treatment?	❒	❒	❒
Is your home water supply fluoridated?	❒	❒	❒
Do you drink bottled or filtered water?	❒	❒	❒
If yes, how often? Circle one: DAILY WEEKLY OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	❒	❒	❒
Do you have earaches or neck pains?	❒	❒	❒
Do you have any clicking, popping or discomfort in the jaw?	❒	❒	❒
Do you brux or grind your teeth?	❒	❒	❒
Do you have sores or ulcers in your mouth?	❒	❒	❒
Do you wear dentures or partials?	❒	❒	❒
Do you participate in active recreational activities?	❒	❒	❒
Have you ever had a serious injury to your head or mouth?	❒	❒	❒

Date of your last dental exam? _____

What was done at that time _____

Date of last dental X-rays? _____

What is the reason for your dental visit today? _____

_____

How do you feel about your smile? _____

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

	Yes	No	DK		Yes	No	DK
Local anesthetics _____	❒	❒	❒	Metals _____	❒	❒	❒
Aspirin _____	❒	❒	❒	Latex (rubber) _____	❒	❒	❒
Penicillin or other antibiotics _____	❒	❒	❒	Iodine _____	❒	❒	❒
Barbiturates, sedatives, or sleeping pills? _____	❒	❒	❒	Hay fever/seasonal _____	❒	❒	❒
Sulfa drugs? _____	❒	❒	❒	Animals _____	❒	❒	❒
Codeine or other narcotics? _____	❒	❒	❒	Food _____	❒	❒	❒
				Other _____	❒	❒	❒

MEDICAL INFORMATION

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Are you now under the care of a physician? _____	❒	❒	❒
Physician Name: _____			
Phone Number ( ) _____			
Address/City/State/Zip _____			
Are you in good health? _____	❒	❒	❒
Has there been any change in your general health within the past year? _____	❒	❒	❒
If yes, what condition is being treated? _____			
_____			
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? _____			
Are you taking or have you recently taken any prescription or over the counter medicine(s)? _____	❒	❒	❒
If so, please list all, including vitamins, natural or herbal preparations an/or diet supplements: _____			
_____			
_____			
Do you wear contact lenses? _____	❒	❒	❒
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfiluramine-phentermine combination):_____	❒	❒	❒
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax® or risedronate (Actonel®) for osteoporosis or Paget's disease?_____	❒	❒	❒
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? _____	❒	❒	❒
Date Treatment began:_____			
Do you use controlled substances (drugs)?_____	❒	❒	❒
Do you use tobacco (smoking, snuff, chew, bidis): _____	❒	❒	❒
If so, how interested are you in stopping? (Circle one) VERY SOMEWHAT NOT INTERESTED			
Do you drink alcoholic beverages? _____	❒	❒	❒
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink in a week? _____			

WOMEN ONLY Are you:

Pregnant?	❒	❒	❒
Number of weeks _____			
Taking birth control pills or hormonal replacement?	❒	❒	❒
Nursing?	❒	❒	❒

JOINT Replacement.

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? _____	❒	❒	❒
If yes have you had any complications? _____	❒	❒	❒

Date: _____

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Heart murmur	❒	❒	❒
Mitral Valve Prolapse	❒	❒	❒
Articial Heart valves	❒	❒	❒
Rheumatic fever	❒	❒	❒
Cardiovascular disease	❒	❒	❒
Angina	❒	❒	❒
Arteriosclerosis	❒	❒	❒
Congestive heart failure	❒	❒	❒
Coronary artery disease	❒	❒	❒
Damaged heart valves	❒	❒	❒
Heart Attack	❒	❒	❒
Low blood pressure	❒	❒	❒
High blood pressure	❒	❒	❒
Congenital heart defects	❒	❒	❒
Pacemaker	❒	❒	❒
Rheumatic heart disease	❒	❒	❒
Abnormal bleeding	❒	❒	❒
Anemia	❒	❒	❒
Blood transfusion	❒	❒	❒
If yes, date_____			
Hemophilia	❒	❒	❒
AIDS or HIV infection	❒	❒	❒
Arthritis	❒	❒	❒
Autoimmune disease	❒	❒	❒
Rheumatoid arthritis	❒	❒	❒
Systemic lupus erythematosus	❒	❒	❒
Asthma	❒	❒	❒
Bronchitis	❒	❒	❒
Emphysema	❒	❒	❒
Sinus trouble	❒	❒	❒
Tuberculosis	❒	❒	❒

	Yes	No	DK
Angina	❒	❒	❒
Cancer/Chemotherapy/Radiation Treatment	❒	❒	❒
Chest pain upon exertion	❒	❒	❒
Chronic pain	❒	❒	❒
Diabetes Type I or II	❒	❒	❒
Eating disorder	❒	❒	❒
Malnutrition	❒	❒	❒
Gastrointestinal disease	❒	❒	❒
G.E. Reflux/persistent heartburn	❒	❒	❒
Ulcers	❒	❒	❒
Thyroid problems	❒	❒	❒
Stroke	❒	❒	❒
Glaucoma	❒	❒	❒
Hepatitis, jaundice or liver disease	❒	❒	❒
Epilepsy	❒	❒	❒
Fainting spells or seizures	❒	❒	❒
Neurological disorders	❒	❒	❒
If yes, Specify:_____			
Sleep disorder	❒	❒	❒
Mental health disorders	❒	❒	❒
Specify _____			
Recurrent infections	❒	❒	❒
Type of infection:_____			
Kidney Problems	❒	❒	❒
Night sweats	❒	❒	❒
Osteoporosis	❒	❒	❒
Persistent swollen glands in neck	❒	❒	❒
Severe headaches/migraines	❒	❒	❒
Severe or rapid weight loss	❒	❒	❒
Sexually transmitted disease	❒	❒	❒
Excessive urination	❒	❒	❒

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ❒ ❒ ❒

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

Do you have any disease, condition, or problem not listed above that you think I should know about? ❒ ❒ ❒

Please explain: _____

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 the form.

Signature of Patient/Legal Guardian_____ Date_____

FOR COMPLETION BY DENTIST

Comments: _____