OTTAVIANO
DENTAL

PATIENT HEALTH HISTORY

Your health and safety are our top priorities. The information you share enables us to provide you with the highest standard of dental care. All responses are kept strictly confidential.

Email: ______________________ Today's Date: ______________________

1. PATIENT INFORMATION

Last ______________________ First ______________________ Middle ____________

Date of Birth: ______________ Sex: ☐ Male ☐ Female Social Security #: ______________

Home Phone: ______________ Cell Phone: ______________

Address: ____

City: ______________________ State: ______ Zip: __________

Occupation: ______________________

Height: ______ ft. ______ in. Weight: ______ lbs.

Emergency Contact: ______________________________

Relationship: ______________________ Phone: ______________________

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

Your Name ______________________ Relationship ______________________

2. DENTAL INFORMATION

Please mark (X) your response.

Question			
Do your gums bleed when you brush your teeth?	☐ Yes	☐ No	☐ Unsure
Are your teeth sensitive to hot, cold, sweets, or pressure?	☐ Yes	☐ No	☐ Unsure
Does food get caught between your teeth?	☐ Yes	☐ No	☐ Unsure
Do you chew on a lot of ice?	☐ Yes	☐ No	☐ Unsure
Have you had any periodontal (gum) treatment?	☐ Yes	☐ No	☐ Unsure
Have you had orthodontic braces or aligners treatment?	☐ Yes	☐ No	☐ Unsure
Have you had any problems associated with your previous dental work?	☐ Yes	☐ No	☐ Unsure
Are you having any dental pain or discomfort?	☐ Yes	☐ No	☐ Unsure

Date of your last dental visit: ______________________

What treatment was completed at that visit? ______________________

Date of your last dental X-rays: ______________________

How would you describe your smile today? ______________________

3. JAW & ORAL HEALTH

Please mark (X) your response.

Question			
Have you had painful or clicking jaw joint treatment?	☐ Yes	☐ No	☐ Unsure
Do you have jaw pain, clicking, popping, or locking?	☐ Yes	☐ No	☐ Unsure
Do you clench or grind your teeth?	☐ Yes	☐ No	☐ Unsure
Do you have sores, ulcers, or lumps in or around your mouth?	☐ Yes	☐ No	☐ Unsure
Do you wear dentures or partials?	☐ Yes	☐ No	☐ Unsure
Do you play contact sports or use a mouthguard?	☐ Yes	☐ No	☐ Unsure
Have you ever had an injury to your head, face or mouth?	☐ Yes	☐ No	☐ Unsure

4. MEDICAL INFORMATION

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

Physician Name: ______________________________ Phone: ______________

Address: ______________________________ City: __________ State: ______ Zip: ______

Are you in good health? ☐ Yes ☐ No

Has there been any change in your general health within the past year? ☐ Yes ☐ No

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? ☐ Yes ☐ No

If yes, what was the illness or problem? ______________________________

Are you taking or have you recently taken any prescription or over-the-counter medications? ☐ Yes ☐ No

If yes, list all (including vitamins, natural, herbal, diet supplements):

____

____

____

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Please check (X) the box that best applies.

1. JOINT REPLACEMENT

Have you had an orthopedic joint implant (replacement, hip, knee, shoulder, elbow, finger, etc.)?

☐ Yes ☐ No ☐ Unsure

Date of joint replacement: ________

If yes, have you had any complications?

☐ Yes ☐ No ☐ Unsure

2. BONE MEDICATION

Are you taking or have you taken medications for osteoporosis, Paget's disease or related conditions? (Examples: Fosamax®, Boniva®, Actonel®, Prolia®, Aredia®, Zometa®)

☐ Yes ☐ No ☐ Unsure

Since 2001, were you treated or are you currently scheduled to begin treatment with bisphosphonates for non-cancer, high blood calcium, or multiple myeloma, or metastatic cancer?

☐ Yes ☐ No ☐ Unsure

Date treatment began: ___________

3. ALLERGIES

Please list any medication, latex, food, tape or other allergies.

	Yes	No	Unsure
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Latex (rubber)	☐	☐	☐
Metals (nickel, chrome, cobalt, etc.)	☐	☐	☐
Iodine	☐	☐	☐
Other ________________	☐	☐	☐

4. MEDICAL HISTORY

Please indicate if you have or have had any of the following conditions.

☐ Artificial (prosthetic) heart valve
☐ Previous infective endocarditis
☐ Congenital heart disease (children)
☐ Other congential heart defects
☐ Cardiovascular disease
☐ Angina
☐ Congestive heart failure (CHF) / heart failure
☐ Damaged valves
☐ Heart attack
☐ Heart murmur
☐ Low blood pressure
☐ High blood pressure
☐ Mitral valve prolapse
☐ Pacemaker
☐ Rheumatic fever
☐ Stroke
☐ Abnormal bleeding
☐ Anemia
☐ Blood transfusion
☐ Hemophilia
☐ Sickle cell anemia
☐ AIDS or HIV infection
☐ Autoimmune disease
☐ Systemic lupus erythematosus
☐ Asthma
☐ Bronchitis
☐ Emphysema
☐ Sinus trouble
☐ Tuberculosis
☐ Arthritis
☐ Diabetes (Type 1 or 2)
☐ Thyroid issues
☐ Malnutrition
☐ Eating disorder
☐ Gastrointestinal disease
☐ GERD (acid reflux)
☐ Ulcers
☐ Fainting Spells
☐ Seizures
☐ Epilepsy
☐ Neurological disorders
☐ Glaucoma
☐ Hepatitis / Jaundice / Liver disease
☐ Kidney problems
☐ Cancer / Chemotherapy / Radiation
☐ Mental health disorders
☐ Anxiety
☐ Osteoporosis
☐ Swollen glands in neck
☐ Sexually Transmitted Diseases
☐ Headaches/Migraines

Do you have any other disease, condition, or problem not listed above? ______________________________

5. WOMEN ONLY

Are you trying to become pregnant? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No
If so number of weeks ________
Are you taking birth control or hormonal replacement? ☐ Yes ☐ No
If yes, what kind? ______________________
Are you nursing? ☐ Yes ☐ No

6. OTHER

Do you use controlled substances (drugs)? ☐ Yes ☐ No
Do you use tobacco (smoking, vaping, snuff, chew, bidis)? ☐ Yes ☐ No
Do you drink alcoholic beverages? ☐ Yes ☐ No

If yes:
How many drinks in last 24 hours ________
How many drinks in a week ________

FINAL SECTION

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

If yes, please provide the name of the provider and contact information:

Provider Name: ________________ Phone: __________

Do you have any medical conditions, allergies, or concerns not listed above that you think we should know about? ☐ Yes ☐ No ☐ Unsure

If yes, please explain:

____
____
____