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# Health History Form

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. This information is vital to allow us to provide the best care for you.

Name: \_\_\_\_\_ Home Phone: *Include area code* \_\_\_\_\_ Business/Cell Phone: *Include area code* \_\_\_\_\_  
 ( ) ( )  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M F  
 SS# or Patient ID: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Home Phone: *Include area code* \_\_\_\_\_ Cell Phone: *Include area code* \_\_\_\_\_  
 ( ) ( )  
 Email: \_\_\_\_\_

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

<i>Your Name</i>	<i>Relationship</i>	
<b>Do you have any of the following diseases or problems:</b>	<i>(Check DK if you Don't Know the answer to the question)</i>	<b>Yes No DK</b>
Active Tuberculosis.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Persistent cough greater than a 3 week duration.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cough that produces blood.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Been exposed to anyone with tuberculosis.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

## Dental Information *Please mark (X) your responses to the following questions.*

Yes No DK	Yes No DK
Do your gums bleed when you brush or floss?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have earaches or neck pains?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your mouth dry?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you brux or grind your teeth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any periodontal (gum) treatments?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have sores or ulcers in your mouth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you wear dentures or partials?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any problems associated with previous dental treatment?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you participate in active recreational activities?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your home water supply fluoridated?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you drink bottled or filtered water?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of your last dental exam: _____
If yes, how often? <i>(Check one:)</i> DAILY <input type="checkbox"/> / WEEKLY <input type="checkbox"/> / OCCASIONALLY <input type="checkbox"/>	What was done at that time? _____
Are you currently experiencing dental pain or discomfort?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of last dental x-rays: _____

What is the reason for your dental visit today?

How do you feel about your smile?

## 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	Yes No DK
Are you now under the care of a physician?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Physician Name: _____ Phone: <i>Include area code</i> _____ ( )	If yes, what was the illness or problem? _____
Address/City/State/Zip: _____	Are you taking or have you recently taken any prescription or over the counter medicine(s)?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are you in good health?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements: _____
Has there been any change in your general health within the past year?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____
If yes, what condition is being treated? _____	_____
Date of last physical exam: _____	_____

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

(Check DK if you Don't Know the answer to the question)

**Yes No DK**

Do you wear contact lenses?

**Joint Replacement.** Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

Date: \_\_\_\_\_ If yes, have you had any complications? \_\_\_\_\_

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?

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: \_\_\_\_\_

**Allergies.** Are you allergic to or have you had a reaction to: To all **yes** responses, specify type of reaction. **Yes No DK**

Local anesthetics

Aspirin

Penicillin or other antibiotics

Barbiturates, sedatives, or sleeping pills

Sulfa drugs

Codeine or other narcotics

**Yes No DK**

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?

**Yes No DK**

Metals \_\_\_\_\_

Latex (rubber) \_\_\_\_\_

Iodine \_\_\_\_\_

Hay fever/seasonal \_\_\_\_\_

Animals \_\_\_\_\_

Food \_\_\_\_\_

Other \_\_\_\_\_

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

**Yes No DK**

Artificial (prosthetic) heart valve

Previous infective endocarditis

Damaged valves in transplanted heart

Congenital heart disease (CHD)

    Unrepaired, cyanotic CHD

    Repaired (completely) in last 6 months

    Repaired CHD with residual defects

*Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.*

<b>Yes No DK</b>	<b>Yes No DK</b>
Cardiovascular disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Mitral valve prolapse <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Angina <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Pacemaker <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Arteriosclerosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rheumatic fever <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Congestive heart failure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rheumatic heart disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Damaged heart valves <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Abnormal bleeding <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Heart attack <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Anemia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Heart murmur <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Blood transfusion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Low blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If yes, date: _____
High blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hemophilia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Other congenital heart defects <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	AIDS or HIV infection <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	Arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

**Yes No DK**

Autoimmune disease

Rheumatoid arthritis

Systemic lupus erythematosus

Asthma

Bronchitis

Emphysema

Sinus trouble

Tuberculosis

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

Do you snore?

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: *Include area code*  
(    )    -    -   

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 this form.

Signature of Patient/Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Dentist: \_\_\_\_\_

Date: \_\_\_\_\_

#### FOR COMPLETION BY DENTIST

Comments: \_\_\_\_\_

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