Star Ranch Dental Spa

Welcome to our office! We are delighted to see you today. This form is intended to help us provide you with the best possible care; so please complete it in its entirety. If you have any questions, please contact our Concierge. As always, your answers are for our records ONLY and all information is kept strictly confidential in accordance with all applicable laws. This office does not use this information to discriminate.

Health History Form

Patient Name: ____________________ Date of Birth: ____________________

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

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Dental Information

(Please answer yes (Y), no (N), or I don't know (D/K) to all questions where applicable)

Do your gums bleed when you brush?		Do you have unpleasant breath?	
Have you ever had orthodontic (braces) treatment?		Have you had any periodontal (gum) treatments?	
Are your teeth sensitive to cold, hot, sweets or pressure?		Does food become caught between your teeth?	
Do you have earaches or neck pains?		Have you had a serious/difficult problem associated with any previous dental treatment?	
Do you clench or grind your teeth while awake or asleep?		If yes, explain:	
Have you experienced clicking or popping of the jaws?		How would you describe your current dental problem?	
Have you had difficulty opening/closing your mouth?		Date of your last dental exam?	
Have you had head, neck, shoulder aches?		Date of your last dental x-rays?	
Do you bite your lips or cheeks regularly?		What was done at your last visit?	
Do you wear removable dental appliances?		How do you feel about the appearance of your teeth?	
Do you mouth breathe while asleep or awake?			
Do you have tired jaws, especially in the morning?		Do you feel nervous about having dental treatment?	
Do you snore at night?		If yes, what is your biggest concern?	

Medical Information: Have you had any of the following diseases or problems?

(Please answer yes (Y), no (N), or I don't know (D/K) to all questions where applicable)

Active Tuberculosis?		Date of last physical examination:	
Persistent Cough greater than a 3 week duration?		Physician Name:	
Cough that produces blood?		Physician Phone Number:	
Are you in good health?		Physician Address, City, State:	
Has there been any change in your general health within the past year?		Have you had orthopedic total joint replacement? (hip, knee, elbow, etc.)	
Have you had any serious illness, operation or been hospitalized within the past 5 years?		Are you alcohol and/or drug dependent?	
If yes, what was the illness or problem?		If so, have you received treatment?	
Are you now under the care of a physician?		Do you use drugs or other substances for recreational purposes?	
If yes, what is/are the condition(s) being treated?		If yes, please list (incl. frequency of use and no. years used:)	
Are you taking, or have you recently taken, any prescription medicines, non-prescription medicines,or vitamins or herbal preparations?		Do you use tobacco (smoking, snuff, chew)?	
If yes, what are you taking?		**WOMEN ONLY:**	
Are you taking, or have you ever taken, any diet drugs such as Pondimin, Redux or phen-fen?		Are you or could you be pregnant?	
Do you drink alcoholic beverages?		Nursing?	
If so, how many in the last week?		Taking birth control pills or hormonal replacement?	

Medical Information Continued…

Are you allergic to or have you had a reaction to any of the following? (Please circle if yes)		Metal (Please specify)
Local anesthesia		Codeine or other narcotics
Aspirin		Latex
Penicillin or other antibiotics		Iodine
Barbiturates, sedatives, or sleeping pills		Hay fever/seasonal
Sulfa drugs		Animals
Food (Please specify)		Other (Please specify)

Please circle to indicate if you have had any of the following diseases or problems:

Abnormal bleeding	Pacemaker	Neurological disorders
Asthma	Rheumatic heart disease/Rheumatic fever	Osteoporosis
AIDS or HIV infection	Chest pain upon exertion	Persistent swollen glands in neck
Anemia	Chronic pain	Emphysema
Arthritis	Disease, drug, or radiation-induced immunosuppression	Bronchitis
Rheumatoid arthritis	Diabetes I (insulin dependent) or II	Severe headaches/migraines
Blood transfusion	Dry mouth	Severe or rapid weight loss
Cancer/Chemotherapy	Eating disorder	Sexually transmitted disease
Angina	Epilepsy	Sinus trouble
Arteriosclerosis	Fainting spells or seizures	Sleep disorder
Artificial heart valves	Gastrointestinal disease	Sores or ulcers in the mouth
Congenital heart defects	G.E. Reflux, persistent heartburn	Stroke
Congestive heart failure	Glaucoma	Systemic lupus erythematosus
Coronary artery disease	Hemophilia	Tuberculosis
Damaged heart valves	Hepatitis, jaundice or liver disease	Thyroid problems
Heart attack	Recurrent infections	Ulcers
Heart murmur	Kidney problems	Excessive Urination
High blood pressure	Mental health disorders	Do you have any disease, condition, or problem not listed above that you think I should know about? If so, please explain:
Low blood pressure	Malnutrition	
Mitral valve prolapse	Night sweats	

I certify that I have read and understand the above. 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

FOR COMPLETION BY DENTIST OR STAFF

Comments on patient interview re: history and significant findings: