

*D. Jack Fong, D.D.S.*  
 amarillo craniofacial pain diagnostic center

American Dental Association Health History

Date \_\_\_\_\_

Name \_\_\_\_\_ Address: \_\_\_\_\_  
 City/State/Zip \_\_\_\_\_ Phone \_\_\_\_\_  
 Occupation \_\_\_\_\_ Business Phone \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Sex: M F Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Nearest Relative \_\_\_\_\_ Phone \_\_\_\_\_  
 If you are completing this form for another person, what is your relationship to that person? \_\_\_\_\_

For the following questions, **CIRCLE YES OR NO**, whichever applies. Your answers are for our records only and are CONFIDENTIAL. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. **THANK YOU!**

- |                                                                                                                                                            |     |    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 1. Are you in good health? .....                                                                                                                           | Yes | No |
| 2. Has there been any change in your general health within the past year? .....                                                                            | Yes | No |
| 3. My last physical examination was on _____                                                                                                               |     |    |
| 4. Are you now under the care of a physician or alternative healthcare provider? .....                                                                     | Yes | No |
| 5. Name of my physician _____                                                                                                                              |     |    |
| 6. Have you or are you taking any of the following? Fosamax/Fosamax D, Didronel, Boniva, Actonel, Skelid, Aredia, Zometa, Bonefos? .....                   | Yes | No |
| 7. Are you taking any medicine(s) including non prescriptions, homeopathics, vitamins, and herbs? .....                                                    | Yes | No |
| If so, please list all medications, non prescriptions, homeopathics, vitamins, and herbs:                                                                  |     |    |
| _____                                                                                                                                                      |     |    |
| _____                                                                                                                                                      |     |    |
| 8. Do you have or have you had any of the following diseases or problems?                                                                                  |     |    |
| a) Rheumatic fever or rheumatic heart disease? .....                                                                                                       | Yes | No |
| b) Cardiovascular disease – please circle (heart trouble, heart attack, coronary occlusion, arteriosclerosis, stroke, mitral valve prolapse, heart murmur? | Yes | No |
| 1) Do you have pain in the chest upon exertion? .....                                                                                                      | Yes | No |
| 2) Are you ever short of breath after mild exercise? .....                                                                                                 | Yes | No |
| 3) Do your ankles swell? .....                                                                                                                             | Yes | No |
| 4) Do you get short of breath when you lie down, or do you require extra pillows to sleep? .....                                                           | Yes | No |
| 5) Do you have a cardiac pacemaker? .....                                                                                                                  | Yes | No |
| c) Allergies? .....                                                                                                                                        | Yes | No |
| d) Sinus trouble? .....                                                                                                                                    | Yes | No |
| e) Asthma or hay fever? .....                                                                                                                              | Yes | No |
| f) Hives or a skin rash? .....                                                                                                                             | Yes | No |
| g) Fainting spells or seizures? .....                                                                                                                      | Yes | No |
| h) Diabetes? .....                                                                                                                                         | Yes | No |
| 1) Do you have excessive thirst or urination? .....                                                                                                        | Yes | No |
| 2) Does your mouth frequently become dry? .....                                                                                                            | Yes | No |
| i) Hepatitis? .....                                                                                                                                        | Yes | No |
| j) AIDS or HIV infection? .....                                                                                                                            | Yes | No |
| k) Respiratory problems, emphysema, bronchitis, etc? .....                                                                                                 | Yes | No |
| l) Arthritis or painful/swollen joints? .....                                                                                                              | Yes | No |
| m) Stomach ulcer or hyper acidity? .....                                                                                                                   | Yes | No |
| n) Kidney trouble? .....                                                                                                                                   | Yes | No |
| o) Tuberculosis? .....                                                                                                                                     | Yes | No |
| p) Persistent cough or cough that produces blood? .....                                                                                                    | Yes | No |
| q) Persistent swollen glands in your neck? .....                                                                                                           | Yes | No |
| r) Low or high blood pressure (if yes, circle which one) .....                                                                                             | Yes | No |
| s) Sexually transmitted diseases? .....                                                                                                                    | Yes | No |

- |                                                                                                                 |     |    |
|-----------------------------------------------------------------------------------------------------------------|-----|----|
| s) Epilepsy or other neurological disease? .....                                                                | Yes | No |
| t) Problems with mental health? .....                                                                           | Yes | No |
| u) Cancer? .....                                                                                                | Yes | No |
| v) Problems with the immune system? .....                                                                       | Yes | No |
| 9. Have you had abnormal bleeding or required a blood transfusion? .....                                        | Yes | No |
| 10. Do you have any blood disorder such as anemia? .....                                                        | Yes | No |
| 11. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your head or neck? ..... | Yes | No |
| 12. Are you taking any of the following?                                                                        |     |    |
| a) Antibiotics or sulfa drugs? .....                                                                            | Yes | No |
| b) Anticoagulants (blood thinners) .....                                                                        | Yes | No |
| c) High blood pressure medication .....                                                                         | Yes | No |
| d) Cortisone (steroids) .....                                                                                   | Yes | No |
| e) Tranquilizers .....                                                                                          | Yes | No |
| f) Antihistamines .....                                                                                         | Yes | No |
| g) Aspirin .....                                                                                                | Yes | No |
| h) Iodine .....                                                                                                 | Yes | No |
| i) Heart Medication.....                                                                                        | Yes | No |
| j) Nitroglycerin .....                                                                                          | Yes | No |
| k) Hormonal therapy.....                                                                                        | Yes | No |
| l) Vitamins, Herbs.....                                                                                         | Yes | No |
| 13. Are you allergic to or have you reacted adversely to:                                                       |     |    |
| a) Local anesthetics .....                                                                                      | Yes | No |
| b) Penicillin/antibiotics .....                                                                                 | Yes | No |
| c) Sulfa Drugs .....                                                                                            | Yes | No |
| d) Barbiturates/Sleeping Pills .....                                                                            | Yes | No |
| e) Aspirin .....                                                                                                | Yes | No |
| f) Iodine .....                                                                                                 | Yes | No |
| g) Codeine/Narcotics.....                                                                                       | Yes | No |
| h) Latex .....                                                                                                  | Yes | No |
| 14. Do you smoke or use smokeless tobacco? .....                                                                | Yes | No |
| 15. Have you been told you need to be premedicated before dental treatment? .....                               | Yes | No |
| 16. Do you have artificial implants or a joint replacement in your body? .....                                  | Yes | No |
| 17. Have you had any serious trouble associated with any previous dental treatment? .....                       | Yes | No |
| 18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? .....  | Yes | No |
| 19. Are you wearing contact lenses? .....                                                                       | Yes | No |
| 20. Do you have skin reactions to any metal and/or jewelry? .....                                               | Yes | No |

**Women:**

- |                                                                       |     |    |
|-----------------------------------------------------------------------|-----|----|
| 21. Are you pregnant? .....                                           | Yes | No |
| 22. Do you have problems associated with your menstrual period? ..... | Yes | No |
| 23. Are you nursing? .....                                            | Yes | No |
| 24. Are you taking birth control pills? .....                         | Yes | No |

**Chief Dental Complaint (please be specific):**

**American Dental Association Early Warning Signs of Periodontal Disease**

- |                                                                    |     |    |
|--------------------------------------------------------------------|-----|----|
| Do your gums bleed when you brush your teeth?.....                 | Yes | No |
| Are your gums swollen or tender? .....                             | Yes | No |
| Are there gums that have pulled away from the teeth? .....         | Yes | No |
| Are there any changes in the way your teeth fit when biting? ..... | Yes | No |
| Are there permanent teeth that are loose or separating? .....      | Yes | No |
| Is there any change in the fit of your partial denture? .....      | Yes | No |
| Have you ever had periodontal disease or gum surgery? .....        | Yes | No |
| Do you have any concerns about the appearance of your teeth?.....  | Yes | No |
| Do you have any concerns about the position of your teeth? .....   | Yes | No |
| Do you have concerns about the shape of your teeth? .....          | Yes | No |
| Do you have concerns about the color or shade of your teeth? ..... | Yes | No |

**Early Warning Signs of Temporomandibular Joint Disease**

- |                                                                         |     |    |
|-------------------------------------------------------------------------|-----|----|
| Do you have chronic headaches? .....                                    | Yes | No |
| Do you have chronic neck pain or stiffness? .....                       | Yes | No |
| Do you have ringing, buzzing or clogged ears? .....                     | Yes | No |
| Do you have pain in the ears or face? .....                             | Yes | No |
| Do you have clicking or grinding noises in your jaw joints? .....       | Yes | No |
| Do you grind, clench or brux your teeth? .....                          | Yes | No |
| Do you chew on only one side of your mouth? Which one? Right Left ..... | Yes | No |
| Do your teeth or jaws ever feel "tired" when you wake up? .....         | Yes | No |

I certify that I have read and understand the above. I acknowledge that my questions, if any about the inquires 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 errors or omissions that I may have made in the completion of this form.

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Signature of Patient or Parent if under 18 years old

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Any other comments about your health and or teeth you would like us to know: