TALL GRASS DENTAL ASSOC.
24111 WEST 103RD STREET ● NAPERVILLE, ILLINOIS 60564
PHONE 630.922.0005 ● FAX 630.922.0003

HEALTH HISTORY FORM

ABOUT YOU

Name: _____ (Last / First / MI / Mr Mrs Ms Dr)
Preferred Name: _____ □ Male □ Female
Email Address: _____
DOB: _____ Age: _____ SS#: _____
Home Address: _____
_____ (City / State / Zip)
□ Single □ Married □ Partnered □ Divorced/Separated □ Widowed
Spouse Name: _____Spouse DOB: _____
Children Name / Age: _____
_____
Home #: (____) _____ Cell #: (____) _____
Work:(____) _____ Ext: _____
Where & when are the best times to reach you? _____
Other family members seen by us? _____
How did you hear of us? _____

EMPLOYER

Employer Name: _____
Employer's Address: _____
_____ (City / State / Zip)
How long there? _____ Occupation: _____

DENTAL HISTORY

Why are you here today? _____
_____

Currently in pain? □ Yes □ No
Are your teeth sensitivity to cold or hot foods? □ Yes □ No
Are your teeth sensitive to biting? □ Yes □ No
Do you have any loose teeth? □ Yes □ No
Do you require antibiotics before treatment? □ Yes □ No
Any serious problems with previous dental work? □ Yes □ No
Brush Daily? □ Yes □ No Floss Daily? □ Yes □ No
Do your gums bleed when you brush or floss? □ Yes □ No
Have you been diagnosed with periodontal disease? □ Yes □ No
Do you have dry mouth? □ Yes □ No
Do you have TMJ (jaw joint) pain or clicking? □ Yes □ No
Are you happy with your smile? □ Yes □ No
If not, what would you change? _____
_____
_____
Are you interested in orthodontic treatment? □ Yes □ No
Are you interested in cosmetic dental treatment? □ Yes □ No
Are you interested in tooth whitening? □ Yes □ No

MEDICAL HISTORY

Do you currently have a primary care physician? □ Yes □ No
Physician's Name: _____
Phone #: _____ Date of Last Visit: _____
Are you currently under the care of a physician? □ Yes □ No
Please explain: _____
Do you take prescription medications? □ Yes □ No
Please list: _____
Do you have any allergies? □ Yes □ No
Please list: _____
Have you recently been hospitalized? □ Yes □ No
When and for what? _____
Do you smoke: □ Yes □ No How many packs per day? _____
Have you ever had any of the following medical problems?

□ Y □ N Asthma
□ Y □ N Autoimmune disease
□ Y □ N Arthritis
□ Y □ N Artificial joints or heart valves
□ Y □ N Bleeding abnormalities
□ Y □ N Cancer / Chemotherapy / Radiation
□ Y □ N Congenital heart defect
□ Y □ N Diabetes (Type I or II)
□ Y □ N Difficulty laying back or sitting up
□ Y □ N Emphysema / Chronic bronchitis
□ Y □ N Epilepsy
□ Y □ N Glaucoma
□ Y □ N Heart attack or stroke
□ Y □ N Heart murmur or arrhythmia
□ Y □ N Heart surgery / pacemaker / defibrillator
□ Y □ N High Blood pressure
□ Y □ N HIV / Hepatitis
□ Y □ N Infective endocarditis / joint infection
□ Y □ N Kidney disease
□ Y □ N Liver disease
□ Y □ N Sickle Cell Disease / Trait
□ Y □ N Thyroid problems
□ Y □ N Tuberculosis

Please list any additional medical conditions or hospitalizations that you have had: _____
_____
Have you ever taken a bisphosphonate drug (Fosamax)? □ Yes □ No
Have you ever taken Phen-fen? □ Yes □ No

Patient Signature_____ Date_____