Highlands Dental Care

2770 S. Highland Ave, Unit 103
Lombard, IL – 60148
Phone: (630) 426 -6996

Health History

As required by our 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 law. This office doesn't use this information to discriminate.

Name (Last, First)			
SSN		Date of Birth	
Sex		Emergency Contact	
Phone			

Medical History

Physician					Office Phone									
Date of Last Exam														
Are you under medical treatment now?										☐ Yes		☐ No		
Have ever been hospitalized for any surgical operation or serious illness within the last 5 years?										☐ Yes		☐ No		
If yes, please explain														
Are you taking any medication(s) including non-prescription medicine?										☐ Yes		☐ No		
If yes, what medication(s) are you taking?										☐ Yes		☐ No		
Have you ever taken Fen-Phen/Redux?										☐ Yes		☐ No		
Have you ever taken Fosamax, Boniva, Actoner or any cancer medications containing bisphosphonates?										☐ Yes		☐ No		
Do you use tobacco?										☐ Yes		☐ No		
Do you use controlled substances?										☐ Yes		☐ No		
Do you have or have you had any of the following?										☐ Yes		☐ No		
High blood pressure		Yes		No	Heart Disease		Yes		No	Heart Attack		Yes		No
Cardiac Pacemaker		Yes		No	Rheumatic Fever		Yes		No	Heart Murmur		Yes		No
Swollen Ankles		Yes		No	Angina		Yes		No	Cancer		Yes		No
Frequently Tired		Yes		No	Asthma		Yes		No	Anemia		Yes		No
Low Blood Pressure		Yes		No	Emphysema		Yes		No	Diabetes		Yes		No
Fainting/Seizures		Yes		No	Leukemia		Yes		No	Arthritis		Yes		No
Epilepsy/Convulsions		Yes		No	Osteoporosis		Yes		No	Kidney Disease		Yes		No
Hepatitis/Jaundice		Yes		No	AIDS/HIV Infection		Yes		No	Thyroid Problem		Yes		No
Sexually Transmitted Disease		Yes		No	Stomach Troubles/Ulcers		Yes		No	Acid Reflex		Yes		No
Joint Replacement/Implant		Yes		No	Chest Pains		Yes		No	Easily Wounded		Yes		No
Hay Fever/Allergies		Yes		No	Tuberculosis		Yes		No	Stroke		Yes		No
Radiation Therapy		Yes		No	Liver Disease		Yes		No	Glaucoma		Yes		No
Recent Weight Loss		Yes		No	Heart Trouble		Yes		No	Respiratory Problem		Yes		No
Mitral Valve Prolapse		Yes		No	Other									

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Dental History

Name of Previous Dentist & Location		
Date of Last Exam		
1. Do your gums bleed while brushing or flossing?	☐ Yes	☐ No
2. Are your teeth sensitive to hot or cold or pressure or sweets?	☐ Yes	☐ No
3. Does your mouth feel dry?	☐ Yes	☐ No
4. Do you feel pain in any of your teeth?	☐ Yes	☐ No
5. Do you have any sores or lumps in or near your mouth?	☐ Yes	☐ No
6. In the past,		
- Have you had any periodontal (gum) treatment?	☐ Yes	☐ No
- Have you had any problems with previous dental treatment?	☐ Yes	☐ No
- Have you had prolonged bleeding after extraction?	☐ Yes	☐ No
7. Do you have any clicking/popping or discomfort in the jaws?	☐ Yes	☐ No
8. Do you brux or grind your teeth?	☐ Yes	☐ No
9. Do you have ulcers/sores in the mouth?	☐ Yes	☐ No
10. Do you wear dentures/partials?	☐ Yes	☐ No
11. Do you participate in active recreational activities?	☐ Yes	☐ No
12. Have you ever had serious injury to head or mouth?	☐ Yes	☐ No
13. Do you drink bottled/filtered water?	☐ Yes	☐ No
14. Do you grind your teeth?	☐ Yes	☐ No
15. Do you have any neck pains or earaches?	☐ Yes	☐ No
16. Date of last Dental X-Rays	☐ Yes	☐ No
17. What is the reason for your dental visit today?	☐ Yes	☐ No
18. How do you feel about your smile?	☐ Yes	☐ No

I certify that I have read and understood the above; and the information provided by me is accurate to the best of my knowledge. I understand that providing incorrect information can be deleterious to my health. I will not hold my dentist or his staff responsible for any action they take / do-not take because of errors or omissions that I have made in completion of this form.

Signature of Patient/Legal Guardian Date

Signature of Dentist Date

For completion by dentist

Comments