DANIEL N. MINCHIK, D.D.S.
148 EAST AVENUE - SUITE 2B
NORWALK, CT 06851

Health History Form

Name _____ Date _____

Do you have any of the following diseases or problems:	Yes	No
Active Tuberculosis	☐	☐
Persistent cough greater than a 3 week duration	☐	☐
Cough that produces blood	☐	☐
Been exposed to anyone with tuberculosis	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information

For the following questions, please mark (X) your responses to the following questions.

	Yes	No		Yes	No
Do your gums bleed when you brush or floss?	☐	☐	Do your have earaches or neck pains?	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	Do you have any clicking, popping or discomfort in the jaw?	☐	☐
Does food or floss catch between your teeth?	☐	☐	Do you brux or grind your teeth?	☐	☐
Is your mouth dry?	☐	☐	Do you have sores or ulcers in your mouth?	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	Do you wear dentures or partials?	☐	☐
			Do you participate in active recreational activities?	☐	☐
Is your home water supply fluoridated?	☐	☐	Have you ever had a serious injury to your head or mouth?	☐	☐
Do you drink bottled or filtered water?	☐	☐			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			Date of your last dental exam:		
Are you currently experiencing dental pain or discomfort?	☐	☐			
What is the reason for your dental visit today?			What was done at that time?		
			Date of last dental x-rays:		
How do you feel about your smile?					

Medical Information

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

	Yes	No		Yes	No
Are you now under the care of a physician?	☐	☐	Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐
Physician Name: Phone: Include area code ( )			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)?	☐	☐
Are you in good health?	☐	☐	If so, please list all, including vitamins, natural or herbal preparations and or diet supplements:		
Has there been any change in your general health within the past year?	☐	☐			
If yes, what condition is being treated?					
Date of last physical exam:					

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

	Yes	No
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 either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease?	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐
Date Treatment began: _____		

	Yes	No
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?	☐	☐

Allergies - Are you allergic to or have you had a reaction to:

	Yes	No
To all yes responses, specify type of reaction. _____	☐	☐
Local anesthetics _____	☐	☐
Aspirin _____	☐	☐
Penicillin or other antibiotics _____	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐
Sulfa drugs _____	☐	☐
Codeine or other narcotics _____	☐	☐

	Yes	No
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
Artificial (prosthetic) heart valve	☐	☐
Previous infective endocarditis	☐	☐
Damaged vales in transplanted heart	☐	☐
Cogenital heart disease (CHD)	☐	☐
Unrepaired, cyanotic CHD	☐	☐
Repaired (completely) in last 6 months	☐	☐
Repaired CHD with residual desfects	☐	☐

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

	Yes	No
Cardiovascular disease	☐	☐
Angina	☐	☐
Arteriosclerosis	☐	☐
Congestive heart failure	☐	☐
Damaged heart valves	☐	☐
Heart attack	☐	☐
Heart murmur	☐	☐
Low blood pressure	☐	☐
High blood pressure	☐	☐
Other congenital heart defects	☐	☐

	Yes	No
Mitral valve prolapse	☐	☐
Pacemaker	☐	☐
Rheumatic fever	☐	☐
Rheumatic heart disease	☐	☐
Abnormal bleeding	☐	☐
Anemia	☐	☐
Blood transfusion	☐	☐
If yes, date: _____		
Hemophilia	☐	☐
AIDS or HIV infection	☐	☐
Arthritis	☐	☐

	Yes	No
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	☐	☐
Gastrointestional disease	☐	☐
G.E. Reflux/persistent heartburn	☐	☐
Ulcers	☐	☐
Thyroid problems	☐	☐
Stroke	☐	☐
Glaucoma	☐	☐

	Yes	No
Hepatitis, jaundice or liver disease	☐	☐
Epilepsy	☐	☐
Fainting spells or seizures	☐	☐
Neurological disorders	☐	☐
If yes, specify: _____		
Sleep disorder	☐	☐
Mental health disorders	☐	☐
Specify: _____		
Recurrent Infections	☐	☐
Type of infections: _____		
Kidney problems	☐	☐
Night sweats	☐	☐
Osteoporosis	☐	☐
Persistent swollen glands in the neck	☐	☐
Sever 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: (_____) _____

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 staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his 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

Comments: _____