# HEALTH HISTORY FORM

PATIENT NAME:____________________ (Last) ________________ (First) ______ (MI) Gender: ☐ Male ☐ Female

Family Status: Married ☐ Single ☐ Child ☐ Other ☐ Birth date:____________ SS#__________________

Primary Phone Number: ________________________mobile ☐ home ☐ Best Time to Call: AM PM

Address: __________________ City:___________ State:_____ Zip:____________

Email Address: ____________________________________________________________________________

Employer: ____________________________________

If not self, insurance holder information

Name: ________________________ Birth Date: ________________ Employer: ____________________

Emergency Contact Information:

___________________________________ (Full Name) _______________________ (Relationship) __________________________ (Phone Number)

When did you last see your **primary care physician**, approximately? ________________________

Your **Primary Care Physician's** name and phone number:

☐ Manning Regional Health Center, 712-655-2072: Dr. __________________

☐ St. Anthony Clinic, 712-792-2222: Dr. ________________

☐ Other ______________________ Dr.________________ Phone #: ____________________

Have you ever had complications following Dental treatment? If so, please explain:

__________________________________________________________________________________________

__________________________________________________________________________________________

Women Only: Are you Pregnant? Yes ☐ No ☐

If yes, when is the due date? ________________________.

How did you hear about Manning Dental: ☐ Newspaper ☐ Facebook ☐ Cable ☐ Referred________________

List of Medications

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

Please indicate if you have experienced any of the following:

- ☐ Pre-Med – Amox
- ☐ Pre-Med – Clind.
- ☐ Pre-Med – Other
- ☐ Anemia
- ☐ Blood Disease
- ☐ Epilepsy
- ☐ Head injuries
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Venereal Disease
- ☐ Arthritis
- ☐ Cancer
- ☐ Excessive Bleeding
- ☐ Heart Disease
- ☐ HIV
- ☐ Mental Disorders
- ☐ Pregnancy
- ☐ Rheumatism
- ☐ Tuberculosis
- ☐ Artificial Joints
- ☐ Diabetes
- ☐ Fainting
- ☐ Heart Murmur
- ☐ Jaundice
- ☐ Nervous Disorders
- ☐ Radiation Treatment
- ☐ Sinus Problems
- ☐ Tumors
- ☐ Asthma
- ☐ Dizziness
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Other
- ☐ Respiratory Problems
- ☐ Stomach Problems
- ☐ Ulcers
- ☐ Tobacco (smoking or chewing)

List any other health issues or allergies:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

What is the reason for your dental visit today?

- ☐ Cleaning/check-up
- ☐ Other: ____________________________________________________________________

When was your last visit to the **dentist** (if to a different office than Manning Dental)?

______________________________________________________________________________

Prior **Dentist** name, address & phone number:

- ☐ Carroll Dental Associates, Dr. ___________________
- ☐ Carroll Dental Clinic, Dr. ____________________
- ☐ Broad Way Dental, Dr. _____________________
- ☐ Harlan Dental, Dr. ________________________
- ☐ Audubon Dental _________________________
- ☐ Other ___________________________________

Please mark any of the following to indicate YES in response to the question:

- ☐ Do your gums bleed when you brush or floss?
- ☐ Do your teeth experience sensitivity to cold or hot temperatures?
- ☐ Are any of your teeth currently causing you pain?
- ☐ Do you grind your teeth (either consciously or during sleep)?
- ☐ Are any of your teeth loose, or are you concerned about any teeth loosening?
- ☐ Do you currently have any dental implants, dentures or partials?

If any of the previous questions are marked, please explain:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

☐ To the best of my knowledge, all of the information above is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.