F.D. MANALILI,DDS
Morgan Hill Smiles

HEALTH HISTORY

Patient Information

NAME: _____ TODAY'S DATE: _____
AGE: _____ BIRTH DATE: _____ □ Male □ Female
ADDRESS:_____
CITY/STATE/ZIP: _____
EMPLOYED BY: _____
ADDRESS: _____
SS#: _____ HOME PHONE: _____ WORK PHONE: _____
CELL PHONE: _____ Do you receive text messages? Yes No
EMAIL: _____ RESPONSIBLE PARTY:_____
FAMILY PHYSICIAN: _____ PHONE: _____
ADDRESS: _____
FORMER DENTIST: _____ PHONE: _____
ADDRESS: _____
DATE OF LAST DENTAL CARE: _____ DATE OF LAST X-RAYS: _____
How did you find out about our office? _____

DENTAL INSURANCE
Name of Plan _____
Subscriber Name _____
Subscriber SSN _____
Subscriber DOB _____
Group Number _____
Mailing Address
for claims _____
Phone number
for claims _____

MEDICAL INSURANCE
Member Number _____
Group Number _____
Plan Number _____
Name of Primary
Care Physician _____

HEIGHT: _____ feet _____inches

WEIGHT: _____ pounds

NECK SIZE: _____

CIRCLE APPROPRIATE ANSWER

Yes No Is your general health good?
Yes No Has there been a change in your health within the last year?
Yes No Have you been hospitalized or had a serious illness within the last 3 years?
If YES, why? _____
Yes No Are you being treated by a physician now? For what? _____
Date of last medical exam?_____
Yes No Have you had problems with prior dental treatment?
Yes No Are you in pain now?

MEDICAL HISTORY

Yes No Anemia
Yes No Arteriosclerosis
Yes No Artificial joint
Yes No Asthma
Yes No Autoimmune disorders
Yes No Bleeding easily
Yes No Cancer/tumors
Yes No Chiropractic care
Yes No Chronic sinus problems
Yes No Chronic fatigue
Yes No Congestive heart failure
Yes No Current pregnancy
Yes No Depression or psychiatric disorder
Yes No Diabetes
Yes No Difficulty concentrating
Yes No Dizziness
Yes No Emphysema
Yes No Epilepsy
Yes No Family history of diabetes, heart problems
Yes No Fibromyalgia
Yes No Frequent sore throats
Yes No Gastroesophageal Reflux Disease (GERD)
Yes No Hay fever
Yes No Heart disorder
Yes No Heart murmur
Yes No Heart pounding or beating irregularly during the night
Yes No Heart pacemaker
Yes No Heart valve replacement
Yes No Heartburn or a sour taste in the mouth at night
Yes No Hepatitis
Yes No High blood pressure
Yes No HIV/AIDS
Yes No Immune system disorder
Yes No Injury to: □ Face □ Neck □ Head □ Mouth □ Teeth
Yes No Insomnia or frequent waking
Yes No Irregular heart beat
Yes No Jaw joint surgery
Yes No Low blood pressure
Yes No Memory loss
Yes No Migraines
Yes No Morning dry mouth
Yes No Muscle spasms or cramps
Yes No Needing extra pillows to help breathing at night
Yes No Nighttime sweating
Yes No Obstructive sleep apnea
Yes No Osteoarthritis
Yes No Osteoporosis
Yes No Poor circulation
Yes No Postural problems/scoliosis
Yes No Prior orthodontic treatment
Yes No Radiation treatment
Yes No Recent excessive weight gain
Yes No Restless Leg Syndrome
Yes No Rheumatic fever
Yes No Shortness of breath
Yes No Snoring
Yes No Stroke
Yes No Swollen, stiff or painful joints
Yes No Thyroid problems
Yes No Tonsillectomy (have had)
Yes No Wisdom teeth extraction

Other Medical History:

_____

LIST ANY MEDICATIONS WHICH HAVE CAUSED AN ALLERGIC REACTION:

Yes	No	Antibiotics	Yes	No	Local anesthetics
Yes	No	Aspirin	Yes	No	Metals
Yes	No	Barbiturates	Yes	No	Penicillin
Yes	No	Codeine	Yes	No	Plastic
Yes	No	Iodine	Yes	No	Sedatives
Yes	No	Latex	Yes	No	Sleeping pills
Yes	No	Sulfa drugs			

Other allergens:

_____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Yes	No	Antacids	Yes	No	Diet pills
Yes	No	Antibiotics	Yes	No	Heart medication
Yes	No	Anticoagulants	Yes	No	High blood pressure medication
Yes	No	Antidepressants	Yes	No	Insulin
Yes	No	Anti-inflammatory drugs (non-steroid)	Yes	No	Muscle relaxants
			Yes	No	Nerve pills
Yes	No	Barbiturates	Yes	No	Pain medication
Yes	No	Blood thinners	Yes	No	Sleeping pills
Yes	No	Codeine	Yes	No	Sulfa drugs
Yes	No	Cortisone	Yes	No	Tranquilizers

Other current medications:_____

WOMEN ONLY:

Yes	No	Are you or could you be pregnant or nursing?
Yes	No	Taking birth control pills?

CHILDREN ONLY:

Yes	No	ADD/ADHD	Yes	No	Sleep walking/talking
Yes	No	Oral habits such as sucking on thumbs, fingers, blankets or other objects	Yes	No	History of tubes in the ears
			Yes	No	Grinding teeth at night
			Yes	No	Mouth breathing
Yes	No	Bed wetting			

Family History

1. Have any members of your family (blood kin) had:	Yes	No	Heart Disease
	Yes	No	High blood pressure
	Yes	No	Diabetes
2. Have any immediate family members been diagnosed Or treated for a sleep disorder?	Yes	No	

Social History

Alcohol consumption: How often do you consume alcohol within 2-3 hours of bedtime?

Never Once a week Several days a week Daily Occasionally

Sedative consumption: How often do you take sedatives within 2-3 hours of bedtime?

Never Once a week Several days a week Daily Occasionally

Caffeine consumption: How often do you consume caffeine within 2-3 hours of bedtime?

Never Once a week Several days a week Daily Occasionally

Do you smoke? Yes No If yes, enter the number of packs per day (or other description of quantity)

_____

Do you use chewing tobacco? Yes No

EPWORTH SLEEPINESS SCALE:

How likely are you to doze off or fall asleep in the following situations?

√ **Check one in each row:**	**0** **No chance of dozing**	**1** **Slight chance of dozing**	**2** **Moderate chance of dozing**	**3** **High chance of dozing**
Sitting and reading				
Watching TV				
Sitting inactive in a public place (e.g. a theater or a meeting)				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a lunch without alcohol				
In a car, while stopped for a few minutes in traffic				

Total Score: _____
(Add columns 0-3)

Emergency contact: Name_____ Relation: _____

Phone #1: _____ Phone #2: _____

I authorize the release of a full report of examination findings, diagnosis, treatment programs, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all fees for treatment regardless of insurance coverage.

Signature_____ Date_____