

Health History

Please fill out completely

Name _____ Date _____

Date of last health care exam _____ What was this exam for? _____

Have you been hospitalized in the last five years? Yes No If yes, reason _____

Are you currently receiving care? Yes No If yes, nature of care _____

Please list the names and phone numbers of all physicians who are currently providing you care.

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

For the following questions, please mark yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit, you will be asked some questions about your responses. Our team may ask additional questions concerning your health.

- | | |
|---|--|
| Anemia or Blood Disorder _____ <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis, any form _____ <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism, or other inflammatory disease _____ <input type="checkbox"/> Yes <input type="checkbox"/> No | Joint Replacement (when placed _____) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma _____ <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease _____ <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Abnormal Bleeding from a cut _____ <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease (including jaundice) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer or Tumor _____ <input type="checkbox"/> Yes <input type="checkbox"/> No | Sore/Enlarged Lymph Nodes _____ <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes _____ <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychosis _____ <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema or other Respiratory/Lung Illness _____ <input type="checkbox"/> Yes <input type="checkbox"/> No | Previous Biopsies _____ <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy _____ <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation or Chemotherapy treatment _____ <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fainting or Dizzy Spells _____ <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever _____ <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glaucoma _____ <input type="checkbox"/> Yes <input type="checkbox"/> No | Slow-Healing Mouth Sores _____ <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Abnormal Heart or Previous Bacterial Endocarditis _____ <input type="checkbox"/> Yes <input type="checkbox"/> No | Unintentional Weight Loss/Gain _____ <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve or Heart Transplant _____ <input type="checkbox"/> Yes <input type="checkbox"/> No | H.I.V. Infection/AIDS or ARC _____ <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Disease _____ <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease _____ <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Disease, Heart Attack, Heart Surgery _____ <input type="checkbox"/> Yes <input type="checkbox"/> No | Other Conditions _____ <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Stent (when placed _____) <input type="checkbox"/> Yes <input type="checkbox"/> No | Recurrent Illnesses _____ <input type="checkbox"/> Yes <input type="checkbox"/> No |

Are you taking any of these medications?

- | | |
|---|--|
| Pre-medication before dental treatment _____ <input type="checkbox"/> Yes <input type="checkbox"/> No | Tagamet (cimetidine) or Prilosec (omeprazole) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Antacids _____ <input type="checkbox"/> Yes <input type="checkbox"/> No | Cardizem (diltiazem) or Calan, Isoptin (Verapamil) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dilantin or Tegretol _____ <input type="checkbox"/> Yes <input type="checkbox"/> No | Serzone (nefazodone) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Barbiturates (any) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No | Diflucan (fluconazole) or Sporonox (itraconazole) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No |
| St. John's Wort or Kava-Kava _____ <input type="checkbox"/> Yes <input type="checkbox"/> No | Biaxin (clarithromycin) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No |

Have you been treated with Bisphosphonate medications (Fosamax, Aredia, Zometa, Actonel, Boniva) Yes No

If so, when did the treatment begin? _____ When did the treatment end? _____

Have you ever taken any prescription for weight loss (such as fen-phen)? Yes No

Do you consume grapefruit juice, grapefruits, or grapefruit extract? Yes No

Please list any medications you are currently taking and dosages. (Exact names and dosing are required.)

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Please list any dietary or herbal supplements you are taking and why.

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |



Women:

- Are you pregnant? Yes No
- If no, are you planning a pregnancy in the near future? Yes No
- Are you a nursing mother? Yes No
- Are you taking birth control pills? Yes No

Abnormal Blood Pressure:

Have you ever received a diagnosis of "high blood pressure"? Yes No

What is your normal blood pressure? _____ / _____ Today _____ / _____

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

- | | | | |
|---------------------------------------|--|---|--|
| Local Anesthetics _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Codeine, Valium, or other sedatives _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Penicillin or other antibiotics _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex or Metals _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Aspirin, Ibuprofen, or Tylenol _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other (please specify) _____ | |

Do you use tobacco? Yes No If yes, what type? Smoke Chew

How much per day? _____ For how long? _____ Do you want to quit using tobacco? Yes No

Do you consume alcohol? Yes No If yes, approximately how many alcoholic beverages per week? _____

Do you use any mood altering drugs other than those previously listed? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency who may release such information to you. I will notify the doctor of change in my health and medication.

➤ _____ Patient (Print Name) _____ Patient Signature _____ Date

➤ _____ Doctor (Print Name) _____ Doctor Signature _____ Date

Doctor's Use Only

Comments on patient interview concerning medical history: _____

Significant findings from questionnaire or oral interview: _____

Dental management considerations: _____
