HEALTH HISTORY

Patient's Name | Date of Birth | Height | Weight | Date

Answer all questions by circling Yes (Y) or No (N) All responses are kept confidential

1. Are you in good health? .....Y N
2. Has there been any change in your general health in the past year? .....Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? .....Y N
5. Have you **ever** had any serious illnesses, **operations** or hospitalizations? If so, describe: .....Y N

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****CIRCLE ALL THAT APPLY****

6. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? .....Y N
   - B. Congenital Heart Disease? .....Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker, Artificial valves)? .....Y N
   - D. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing, Sleep Apnea)? .....Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness? .....Y N
   - F. Bleeding Disorder, Abnormal bleeding, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? .....Y N
   - G. Liver Disease (Jaundice, Hepatitis)? .....Y N
   - H. Kidney Disease? .....Y N
   - I. Diabetes? .....Y N
   - J. Thyroid Disease (Goiter)? .....Y N
   - K. Arthritis or painful swollen joints including jaw joint (TMJ disorder)? .....Y N
   - L. Stomach Ulcers or Colitis? .....Y N
   - M. Glaucoma? .....Y N
   - N. Osteoporosis? .....Y N
   - O. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? .....Y N
   - P. Radiation (X-ray) treatment for Cancer? .....Y N
   - Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? .....Y N
   - R. Sinus or Nasal problems? .....Y N
   - S. Any disease, drug or transplant operation that has depressed your immune system? .....Y N
   - T. Have you ever had treatment for a tumor or growth? ..... Y N
   - U. Frequent or recurring mouth sores? .....Y N
   - V. Persistent cough or cough that produces blood? ....Y N
   - W. Persistent swollen neck glands? .....Y N
   - X. Low blood pressure? .....Y N
   - Y. Hereditary Angioedema? .....Y N
   - Z. Unusual soft tissue swelling after dental procedures? .....Y N
   - AA. High Cholesterol? .....Y N

7. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? .....Y N
   - B. Anticoagulants (Blood Thinners)? .....Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? .Y N
   - D. High Blood Pressure medications? .....Y N
   - E. Steroids (Cortisone, Prednisone, etc.)? .....Y N
   - F. Tranquilizers? .....Y N
   - G. Insulin or Oral Anti-Diabetic drugs? .....Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
   - I. Are you taking or ***have you ever taken*** Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia) ? .....Y N
   - J. Do you or have you smoked marijuana (Pot, Weed, Cannabis, Ganja, Reefer) in the last year? .....Y N
   - K. Have you ever been advised <u>not</u> to take a medication? .....Y N
   - L. Please list any and **all medications** taken, including prescription and over-the-counter medications, diet drugs, herbal or holistic remedies, vitamins or minerals (use back of sheet for more space): _____

_____

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8. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novacain, etc.)? .....Y N
   - B. Penicillin, Sulfa or other antibiotics? .....Y N
   - C. Sedatives, Barbiturates? .....Y N
   - D. Aspirin or Ibuprofen? .....Y N
   - E. Codeine or other pain killers? .....Y N
   - F. Latex or Rubber products? .....Y N
   - G. Metal of any kind? .....Y N
   - H. Chemicals or jewelry (rash or sensitivity)? .....Y N
   - I. Food products? .....Y N
   - J. Other allergies or reactions? Please list .....Y N

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_____

9. Do you have a history of smoking or chewing Tobacco? Y N
   How much per day? _____
10. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? .....Y N
11. Have you had any serious problems associated with any previous dental treatment? .....Y N
12. Have you or an immediate family member had any problem associated with intravenous anesthesia? .....Y N
13. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? .....Y N
14. Do you wish to talk to the doctor privately about anything? .....Y N
15. Have you ever had a bone density scan? .....Y N
16. Are you wearing contact lenses? ..... Y N
17. Are you wearing removable dental appliances? .....Y N
18. **Are you currently under the care of a pain management clinic? .....Y N**

(please write name of doctor, clinic and phone number on back)

19. **FOR WOMEN ONLY**
   - A. Are you Pregnant, or **<u>is there any chance</u>** you might be Pregnant? .....Y N
   - B. Are you nursing? .....Y N
   - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

FLIP OVER TO FINISH FORM ON BACK
(fill out highlighted areas)

I understand the importance of a truthful and complete Health History to assist my dentist in providing the best care possible. I have had the opportunity to discuss my Health History with my dentist.

Date _____ Signature of Person Completing Health History _____ Doctor's Initials _____

Chief Dental Complaint:_____

_____

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Date: _____ Patient's Signature: _____

FOR COMPLETION BY THE DOCTOR

Comments on patient interview concerning medical history: _____

_____

_____

Significant findings from questions or oral interview: _____

_____

_____

Dental Management Considerations: _____

_____

_____

Date: _____ Dentist's Signature: _____

***We are now REQUIREDto send all prescriptions electronically. Please fill out below the pharmacy of your choice.**

Pharmacy Information:

Name of Pharmacy:_____

Pharmacy Phone Number:_____

Pharmacy Address:_____