HEALTH HISTORY

Patient's Name: _____ **Birthdate:** _____ **Phone:** _____

Address: _____ **Email:** _____

Answer all questions by circling Yes (Y) or No (N)

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 physcian's care for a particular problem? What? ..... Y N
5. Have you ever had any serious illnesses, operations or hospitalizations? If so, describe ..... Y N

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6. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Arthritis? ..... Y N
   - B. Any disease, drug or transplant operation that has depressed your immune system? ..... Y N
   - C. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bleed easily? ..... Y N
   - D. Cancer? Type _____ ..... Y N
   - E. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, (Mitral Valve Prolaspe, Rheumatic Fever), Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpatations, Heart Surgery, Pacemaker, Stent? ..... Y N
   - F. Clicking or popping jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? . Y N
   - G. Congenital Heart Disease? ..... Y N
   - H. Diabetes? ..... Y N
   - I. Glaucoma? ..... Y N
   - J. Implants or artificial joints placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? .... Y N
   - K. Kidney Disease? ..... Y N
   - L. Liver Disease (Jaundice, Hepatitis)? ..... Y N
   - M. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain? ..... Y N
   - N. Radiation (X-ray) treament for Cancer? ..... Y N
   - O. Rheumatic Fever or Rheumatic Heart Disease .. Y N
   - P. Seizures, Convulsions, Epilepsy, Fainting or Dizziness? ..... Y N
   - Q. Sinus or Nasal problems? ..... Y N
   - R. Stomach Ulcers or Colitis? ..... Y N
   - S. Thyroid Disease (Goiter)? ..... 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 Aleve, Ibuprofen? ..... Y N
   - D. High Blood Pressure medications? ..... Y N
   - E. Steroids (Cortizone, Prednizone, etc.)? ..... Y N
   - F. Tranquilizers? ..... Y N
   - G. Insulin or Oral Anti-Diabetic drugs? ..... Y N
   - H. Have you ever been given Prolla, Xgeva Avastin? Y N

All responses are kept confidential

- H. Digitalis, Inderal, Nitroglycerin or other heart drug? ..... Y N
- I. Bisphosphonate (Fosamax, Boniva, Actonel, Aredia, Zometa, Skelid, Didronel) ..... Y N
- J. Bisphosphonate Reclast Injection once a year? ..... Y N

8. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)? ..... Y N
   - B. Penicillin or other antibiotics? ..... Y N
   - C. Sedatives, Barbiturates, Sulfites? ..... Y N
   - D. Aspirin or Ibuprofen? ..... Y N
   - E. Codeine or other pain killers? ..... Y N
   - F. Latex or Rubber Products? ..... Y N
   - G. Eggs or Soybeans? ..... Y N
   - H. Other allergies or reactions? Please list ..... Y N

_____

_____

9. Do you smoke or chew 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. Do you use recreational drugs? List ..... Y N
12. Have you had any serious problems associated with any previous dental treatment? ..... Y N
13. Have you or an immediate family member had any problem associated with anethesia? ..... Y N
14. Is there anything else we should know about your medical history? ..... Y N
15. Do you wish to talk to the doctor privately about anything? ..... Y N
16. **MEDICATIONS**
    Please list any medications you are taking on the back side of this form.
17. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **is there any chance** you might be Pregnant? ..... Y N
    - B. **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 mechancial 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.

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

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

Medical Doctor's Name: _____

Medical Doctor's Phone: _____

Please list any and all medications taken, including prescription medications, over the counter medications, herbal or holistic remedies, vitamins or minerals:

DOCTOR'S NOTES: _____