HEALTH HISTORY

Name ______________________________ Today's Date ____________________

Date of Birth ______________________ Age ________ Height ________ Weight ________

Date of last health care exam: ______________ What was this exam for? ____________________

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

Have you ever had any serious illness, surgery or been hospitalized? (Please circle) No Yes

If yes, reason: ____

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

1. ____
2. ____
3. ____
4. ____

For the following medical conditions circle 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 response. Our team may ask additional questions concerning your health.

Blood Pressure: High Low	No	Yes	Stroke?	No	Yes
Diabetes	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Heart Disease, Angina, Heart Attack, Heart Surgery	No	Yes	Fainting or Dizzy Spells	No	Yes
Heart Stent or Pacemaker When placed?	No	Yes	Kidney Disease	No	Yes
Heart Valve (damaged/artificial) or Heart Transplant	No	Yes	Renal Dialysis	No	Yes
H.I.V. Infection/AIDS or ARC	No	Yes	Glaucoma	No	Yes
Women: Are you pregnant? Are you trying to become pregnant?	No No	Yes Yes	Cancer or Tumor? Radiation or Chemotherapy?	No No	Yes Yes
Asthma or other Lung Diseases	No	Yes	Psychiatric or Mental Health Therapy	No	Yes
Emphysema or COPD other Respiratory Illness	No	Yes	Joint Replacement? When placed?	No	Yes
Sleep Apnea?	No	Yes	Previous Bacterial Endocarditis	No	Yes
Liver Disease, Jaundice, or Cirrhosis	No	Yes	Allergies? Sinus Trouble?	No	Yes
Hepatitis, Any Form	No	Yes	Slow-Healing Mouth Sores	No	Yes
Arthritis, Rheumatism or other inflammatory disease	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Blood Disorders? Abnormal Bleeding from a cut?	No	Yes	Previous Biopsies	No	Yes
Congenital Heart Disease?	No	Yes	Venereal Disease	No	Yes
Thyroid Problems?	No	Yes	Other Conditions	No	Yes
Epilepsy or other neurological disease?	No	Yes	Recurrent Illnesses	No	Yes
Is there any other problem you think I should know about?	No	Yes			

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Tagamet® (cimetidine) or Prilosec® (omeprazole)?	No	Yes
Antacids?	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Serzone® (nefazodone)	No	Yes
Dilantin® or Tegretol®	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
Barbiturates (any)	No	Yes	Biaxin® (clarithromycin)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®, RECLAST) or PROLIA? If so, when did the treatment begin? When did the treatment end?				No	Yes
Have you ever taken any prescription drugs such as fen-phen for weight loss?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

Please list any medications you are currently taking, the dosages and the reason for the medication:

1. ____________________ 2. ____________________
3. ____________________ 4. ____________________
5. ____________________ 7. ____________________
6. ____________________ 8. ____________________

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Please list any dietary or herbal supplements you are taking, and for what purpose:

1. ______________________ 2. ______________________
3. ______________________ 4. ______________________
5. ______________________ 6. ______________________

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

Abnormal Blood Pressure? (Please circle) No Yes
Have you ever received a diagnosis of "high blood pressure" or "low blood pressure"?
What is your normal blood pressure? S /D Today: ____________/__________

Are you allergic or have you had a reaction to:

a. Local anesthetics or epinephrine…………………………………….... No Yes
b. Penicillin or other antibiotics ………………………………………… No Yes
c. Aspirin, Ibuprofen or Tylenol® …..…………………………………… No Yes
d. Codeine, Valium®, Hydrocodone, Oxycodone or other sedatives……… No Yes
e. Latex or Metals
f. Other (please specify)______________________________

Chief Dental Complaint: ______________________________
Have you had any trouble associated with any previous dental work? ______________________
Are you wearing any removable dental appliances? No Yes

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

Weight and Diet considerations

Weight	Meals per Day	Dietary Restrictions	Food Allergies
Sugar in your diet (circle one): *none slight moderate high*			

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:

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