HEALTH HISTORY

Name _____ Date _____

Date of last health care exam: _____What was this exam for?_____

Have you been hospitalized or had surgery? (Please circle) No Yes

If yes, reason:_____

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

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

1. _____
2. _____
3. _____
4. _____

For the following questions 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 Disorders?	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes
Asthma, COPD or other Lung Diseases	No	Yes
Abnormal Bleeding from a cut?	No	Yes
Cancer or Tumor?	No	Yes
Diabetes	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes
Epilepsy	No	Yes
Fainting or Dizzy Spells	No	Yes
Glaucoma	No	Yes
Previous Bacterial Endocarditis	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes
Congenital Heart Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery, Angina	No	Yes
Heart Stent? When placed?	No	Yes
Hepatitis, Any Form	No	Yes
Joint Replacement? When placed?	No	Yes
Kidney Disease	No	Yes
Liver Disease (including Jaundice)	No	Yes
Sore/Enlarged Lymph Nodes	No	Yes
Psychiatric Therapy	No	Yes
Previous Biopsies	No	Yes
Radiation or Chemotherapy Treatment	No	Yes
Renal Dialysis	No	Yes
Slow-Healing Mouth Sores	No	Yes
Unintentional Weight Loss/Gain	No	Yes
H.I.V. Infection/AIDS or ARC	No	Yes
Venereal Disease	No	Yes
Other Conditions	No	Yes
Recurrent Illnesses	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

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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 and dosages:

1._____ 2._____ 3._____
4._____ 5._____ 6._____
7._____ 8._____ 9._____

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"? No Yes
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 No Yes
f. Other (please specify)_____

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

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***