HEALTH HISTORY

Name ____ Date ___________________________

Date of last health care exam: _______________What was this exam for? ________________________________

Have you been hospitalized in the last 5 years? (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.

Heart Murmur (mitral valve prolapse)	No	Yes	Psychosis	No	Yes
Anemia	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Slow-Healing Mouth Sores	No	Yes
Hepatitis, Any Form	No	Yes	Other Infections	No	Yes
Rheumatic Fever	No	Yes	Recurrent Illnesses	No	Yes
Asthma	No	Yes	Joint Replacement	No	Yes
High Blood Pressure	No	Yes	Glaucoma	No	Yes
Emphysema or any Respiratory Illnesses	No	Yes	Abnormal Bleeding from a cut	No	Yes
Abnormal Heart Condition	No	Yes	Liver Disease (including Jaundice)	No	Yes
Kidney Disease	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart (Surgery, Disease, Attack)	No	Yes	Latex Sensitivity	No	Yes
Venereal Disease	No	Yes	H.I.V. Infection/AIDS	No	Yes
Artificial Heart Valve	No	Yes	Artificial Joint	No	Yes
Heart Pace Maker	No	Yes	Osteoporosis	No	Yes

Are you required to Pre-Medicate before dental treatment? No Yes

Are you now taking or have taken in the past Fosamax, Actonel, Boniva or any other Biophosphonate (often used in treatment of osteoporosis)? No Yes

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

Are you allergic or have you had a reaction to:

a. Local anesthetics ………………………………………………………... No Yes
b. Penicillin or other antibiotics …………………………………………… No Yes
c. Aspirin ….………………..……………………………………………... No Yes
d. Codeine, valium or other sedatives……………………………………… No Yes
e. Latex…………………………………………………………………... No Yes
f. Other ____

Are you a smoker? No Yes
If so, how much do you smoke per day? _______________

Please list any medications you are currently taking:

1. ______________________________ 2. ______________________________
3. ______________________________ 4. ______________________________
5. ______________________________ 6. ______________________________

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Are you taking Tagamet (Cimetidine)? No Yes If yes, how often? ____________________________

Do you take Antacids? No Yes If yes, how often? ____________________________

Are you taking any herbal supplements/medicines? No Yes If yes, which ones?___________________________

Weight: __________

Diet: Restricted Diet ___________________________________
How many meals a day ____________________________
Food Allergies ___________________________________
Sugar in your diet: ❑ 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'S USE ONLY – DO NOT WRITE BELOW THIS LINE

Comments on patient interview concerning medical history:
____
____

Significant findings from questionnaire or oral interview:
____
____

Dental management considerations:
____

Initial/Date ______________
BP ______________
Pulse ______________
SpO2% ______________

Date:____________ Comments:____Initials:______

Date:____________ Comments:____Initials:______

Date:____________ Comments:____Initials:______

Date:____________ Comments:____Initials:______

Date:____________ Comments:____Initials:______

Date:____________ Comments:____Initials:______

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Date:____________ Comments:____Initials:______

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