HEALTH HISTORY

Patient's Name _____ Date of Birth _____ 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

   _____

   _____
6. Height _____ Weight _____
7. **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?) .....Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? .....Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness.....Y N
   - F. Bleeding Disorder, 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?.....Y N
   - L. Stomach Ulcers or Colitis?.....Y N
   - M. Glaucoma?.....Y N
   - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? .....Y N
   - O. Radiation (X-ray) treatment for Cancer? .....Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? .....Y N
   - Q. Sinus or Nasal problems?.....Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system? .....Y N
   - S. Are you HIV positive?..... Y N
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics?.....Y N
   - B. Anticoagulants (Blood Thinners)? .....Y N
   - C. Aspirin or drugs such as Plavix, Warfarin, Coumadin Lovenox, Pradaxa .....Y N
   - D. High Blood Pressure medications? .....Y N
   - E. Steroids (Cortisone, 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 (Fosamax/ Alendronate, Boniva, Ibandronate, Actonel, Risedronate, Zometa, Zolendrate, Zolendronic Acid, Reclast, Aedia, Panidronate, Bone Fos, Clostoban, Loron, Ostac, Clondronate, Didronel, Etidronate, Skelid/, Tiludronate Disodium, Neridronate or Olpadronate for osteoporosis, or chemotherapy for cancer, Paget's Dx, or Multiple Myeloma, etc.……Y N
   - J. Please list any and all medications taken, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:_____

     _____

     _____
9. **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?.....Y N
   - D. Aspirin or Ibuprofen?.....Y N
   - E. Codeine or other pain killers? .....Y N
   - F. Latex or Rubber Products?.....Y N
   - G. Other allergies or reactions? Please, list.....Y N

     _____

     _____
10. Do you smoke or chew Tobacco?.....Y N
    How much per day? _____
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you?.....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 intravenous anesthesia?.....Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?.....Y N
15. Do you wish to talk to the doctor privately about anything? .....Y N
16. **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. Are you using Oral Contraceptives?.....Y N
    - D. Last Menstrual Period _____

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible.

_____ _____ _____

Date Signature of Person Completing Health History Doctor's Initials

Mailing Address_____City, State, Zip_____

Home Phone_____Work_____Cell_____

SS#_____Emergency Contact Name_____PH_____

Referring Doctor_____Dentist_____