HEALTH HISTORY

Patient Name _____ DOB: _____ Age _____

Reason for today's dental visit _____

Please answer each question. Circle yes or no. If in doubt, leave blank.

Are you currently under the care of a physician(s)? Yes No

For what condition(s)_____

Name of primary care physician: _____

Phone #: _____

Have you been hospitalized within the past 3 years? Yes No

If Yes, please explain _____

Please list **ALL MEDICATIONS** you currently take:

_____

_____

_____

Please list any **vitamins, dietary herbs/supplements, or over-the-counter medications** you currently take:

_____

_____

Do you require **antibiotic** pre-medication prior to dental work?

Yes No If yes, name of medication _____

Please list any **ALLERGIES** to medications or materials:

_____

Do you use tobacco? Yes No If yes, type and frequency:

_____

Have you ever had abnormal or prolonged bleeding? Yes No

If yes, please explain _____

(Women Only): Are you pregnant/nursing/using birth control?

Yes No

Are you currently taking or have you taken bisphosphonate medication for osteoporosis, such as Fosamax, Boniva, Actonel or Reclast within the past twelve years?

Yes No If Yes, medication and # years on medication

_____

_____

Do you have, or have you ever had any of the following?

High blood pressure	Yes No
Cardiovascular disease, heart attack	Yes No
Swollen ankles	Yes No
Stroke	Yes No
Chest pain, angina	Yes No
Heart surgery or bypass	Yes No
Prosthetic heart valve	Yes No
Congenital heart disease	Yes No
Heart murmur	Yes No
Mitral valve prolapse (MVP)	Yes No
Rheumatic heart disease or fever	Yes No
Irregular heart beat	Yes No
Cardiac pacemaker	Yes No
Joint prosthesis (hip, knee, etc.)	Yes No
Arthritis or joint disease	Yes No
Difficult breathing/other lung trouble	Yes No
Emphysema, COPD	Yes No
Hay fever or sinus problems	Yes No
Asthma	Yes No
Bronchitis, chronic cough	Yes No
Blood disorder (i.e. - anemia)	Yes No
Delay in healing	Yes No
Bruise easily	Yes No
Eye disease or glaucoma	Yes No
Wear contact lenses	Yes No

Diabetes	Yes No
Low blood sugar	Yes No
Kidney problems	Yes No
Dialysis	Yes No
Hepatitis, jaundice, liver disease	Yes No
Stomach ulcers, colitis	Yes No
GERD, acid reflux, heartburn	Yes No
Gallbladder trouble	Yes No
Cancer If Yes, what type _____	Yes No
Radiation or Chemotherapy	Yes No
Contagious diseases	Yes No
Tuberculosis	Yes No
Problems with the immune system	Yes No
HIV	Yes No
Epilepsy	Yes No
Psychiatric problems	Yes No
Fainting problems	Yes No
Chronic fatigue or night sweats	Yes No
Venereal disease	Yes No
History of drug abuse	Yes No
History of alcohol abuse	Yes No
Temporomandibular joint problem (TMJ)	Yes No

Please complete next page

HEALTH HISTORY

Does dental treatment make you nervous? No _____ Slightly _____ Moderately _____ Extremely _____

Date of last dental visit _____

In what ways can we make your dental visits better? _____

To the best of my knowledge, all of the preceding answers are true and correct.
If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient, Parent or Legal guardian _____Date _____

Please Print Patient Name _____

For Office Use Only:

Initial BP _____ RAS/LAS

Doctor's signature: _____Date _____

Reviewed: _____
_____
_____