HEALTH HISTORY

Patient's Name | Date of Birth | Height | Weight | Date

ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N) **All responses are kept confidential**

1. Have you had any dental treatment in the past 6wks? ..... Y N
2. If yes, please explain _____
   Are you in good health? ..... Y N
3. Has there been any change in your general health in the past year? .... Y N
4. Date of last physical exam _____
5. Are you now under a physician's care? ..... Y N
6. If yes provide M.D. Name and Phone #_____
   _____
   _____
7. Have you **EVER** had any serious illnesses, operations (Angioplasty, Heart Bypass, Heart Valve Replaced, Pacemaker, Strokes, and Cancer)? ..... Y N
   IF SO WHEN: _____
   _____
   _____

8. DO YOU HAVE OR HAVE YOU EVER HAD: (PLEASE CIRCLE)

-Rheumatic Fever or Rheumatic Heart Disease? ..... Y N
-Do you have a Heart Murmur? ..... Y N
-Congenital (at Birth) Heart Disease? ..... Y N
-Congestive Heart Failure? ..... Y N
-Angina (chest pains)? ..... Y N
-Heart Attack? When (date or year) ..... Y N
-High blood pressure? ..... Y N
-High Cholesterol? ..... Y N
-Strokes and/or TIA? ..... Y N
-Asthma? ..... Y N
-COPD treated for Bronchitis or Emphysema? ..... Y N
-Other? ..... Y N
- Pneumonia or Tuberculosis? ..... Y N
-Obstructive Sleep Apnea? ..... Y N
Do you use a CPAP? ..... Y N
-Seizures, Epilepsy? ..... Y N
-Syncope (Fainting) or Dizziness? ..... Y N
-Bleeding Disorder, Anemia? ..... Y N
-Blood Transfusion? ..... Y N
-Liver Disease (Jaundice, Hepatitis A, B, or C?)? ..... Y N
-Kidney Disease? (Renal Failure) ..... Y N
If Dialysis when? M T W Th F Sat Sun ..... Y N
-Diabetes? ..... Y N
-Thyroid Disease (Goiter, Hypo/Hyperthyroidism)? ..... Y N
-Arthritis? ..... Y N
-Stomach Ulcers or Colitis? ..... Y N
-Glaucoma? ..... Y N
-Osteoporosis or Osteopenia? ..... Y N
-Sickle Cell/Trait ..... Y N
-Anxiety? ..... Y N
-Attention Deficit Hyperactivity Disorder (ADHD /ADD) ..... Y N
-Depression, Bipolar, Autism or Psychiatric issues? ..... Y N
-Prosthetic Replacements placed in your body such as (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
-Radiation &/or Chemo treatment for Cancer? ..... Y N
If yes what type of Cancer: _____
_____
-Popping of jaw joint, pain near ear, _____
difficulty opening/closing mouth, grinding of teeth? ..... Y N
-Sinus or Nasal problems? ..... Y N
-Transplant operation that has depressed your immune system? ..... Y N
-HIV? ..... Y N

9. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO?

A. Local Anesthesia (Novocain, Lidocaine, etc.)? ..... Y N
B. Penicillin Allergy? ..... Y N
C. Sulfa Allergy? ..... Y N
D. Other Antibiotic Allergies? ..... Y N
E. Allergic to Iodine? ..... Y N
F. Sedatives, Barbiturates? ..... Y N
G. Aspirin? ..... Y N
H. Ibuprofen (Motrin, Advil, Aleve)? ..... Y N
I. Tylenol/Acetaminophen ..... Y N
J. Codeine or other pain killers? ..... Y N
K. Food products? (**Eggs**) ..... Y N
L. Latex or Rubber Products? ..... Y N
M. Other allergies or reactions? Please list ..... Y N
_____
_____
_____
_____

10. Do you smoke? ..... Y N
    How much per day? _____
11. Do you use snuff or chewing Tobacco? ..... Y N
12. Is there any past history of alcoholism? ..... Y N
    Liquor Beer
13. Have you had a Drug Dependency that may affect the care we provide you (Cocaine, Marijuana, etc)? ..... Y N
14. Have you had any serious problems associated with any previous dental treatment? (bleeding) ..... Y N
15. Has any immediate family member had any problem with anesthesia? (Malignant Hyperthermia) ..... Y N
16. Are there any other disease, condition or problems not listed above you think the doctor should know about? ..... Y N
    If so
    .....
    .....
17. **FOR WOMEN ONLY**
    A. Are you Pregnant, or **is there any chance** You might be Pregnant? ..... Y N
    B. Are you nursing? ..... Y N
    C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

PLEASE LIST MEDICATIONS ON REVERSE SIDE

I understand the importance of a truthful and complete Health History to assist my dentist in providing the best care possible.
I have had the opportunity to discuss my Health History with my dentist.

Date | Signature of Person Completing Health History | Doctor's Initials

18. LIST MEDICATIONS YOU ARE TAKING, including herbal and holistic remedies:

NONE

_____ Mg	_____ Mg
_____ Mg	_____ Mg
_____ Mg	_____ Mg
_____ Mg	_____ Mg
_____ Mg	_____ Mg

IAre you or ***have you EVER taken*** Bisphosphonates for osteoporosis, multiple myeloma or other cancers:

Pamidronate (APD, Aredia)……..Y N	Zoledronate (Zometa, Aclasta)……Y N
Neridronate (Nerixia)……..Y N	Etidronate (Didronel)……..Y N
Olpadronate……..Y N	Clodronate (Benefos, Loron)……Y N
Alendronate (Fosamax)……..Y N	Tiludronate (Skelid)……Y N
Ibandronate (Boniva)……Y N	Denosumab (Xgeva, Prolia)……Y N
Risedronate (Actonel)……..Y N	

|| If so how long have you been taking it? _____

19. HAVE YOU FORGOTTEN TO INCLUDE ANY OF THE FOLLOWING?

A.	Antibiotics you are taking?.....Y N	Aspirin……Y N
B.	Pain medications?.....Y N	Apixaban (Eliquis)……Y N
C.	Steroids (Cortisone, Prednisone, etc.)……Y N	Dabigatran (Pradaxia)….. Y N
D.	Digitalis, Inderal, Nitroglycerin, other heart drugs?.....Y N	Enoxaparin (Lovenox)…..Y N
E.	Have you been told NOT to take a medication?.....Y N	Edoxaban (Savaysa)……Y N
F.	Blood Thinners?.....Y N	Warfarin (Coumadin)…….Y N
		Rivaroxaban (Xarelto)…..Y N
		Clopidogrel (Plavix)……Y N
		Brilinta (Ticagrelor)……..Y N

_____ _____ _____

Date Signature of Person Completing Health History Doctor's Initials

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RETURNING PATIENTS MEDICAL HISTORY UPDATE:

Any Changes: Yes or No
If yes, explain: _____

_____

Any New Medications: Yes or No
If yes, What Medications: _____
_____

Date: _____ Signature _____ Doctor's Initials_____

_____

RETURNING PATIENTS MEDICAL HISTORY UPDATE:

Any Changes: Yes or No
If yes, explain: _____

_____

Any New Medications: Yes or No
If yes, What Medications: _____
_____

Date: _____ Signature _____ Doctor's Initials_____