HEALTH HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

PHYSICIAN'S NAME _____ PHYSICIAN'S ADDRESS _____ PHYSICIAN'S NUMBER _____

MOST RECENT VISIT TO PHYSICIAN _____ REASON _____

HOW WOULD YOU ASSESS YOUR GENERAL HEALTH? O GOOD O FAIR O POOR

OFFICE USE ONLY

Level _____ YES NO

PRE-MED O O

COMMENTS:

DATE_____

To ensure your well being while undergoing treatment in our office, please answer the following questions in detail. All information will be considered confidential and for our records only.

	YES	NO
Are you currently seeing a physician for treatment of a recent or ongoing medical condition?	o	o
Have you been hospitalized within the last year? If yes, explain:	o	o
Have you had a serious illness or operation within the last year? If yes, explain:	o	o
Have you ever had any serious medical trouble associated with any dental experience? If yes, explain:	o	o
Have you ever been advised to take antibiotics (like penicillin, etc.) before a dental appointment? If yes, explain:	o	o

Please check yes or no if you have the following:

1) Diabetes yes o no o
   o Type 1 o Type 2
2) Family history of diabetes yes o no o
3) Artificial joint(s) yes o no o
   If yes, which joint(s) _____
4) Hepatitis yes o no o
5) HIV positive yes o no o
6) Have reason to suspect you have been exposed to the HIV virus? yes o no o
7) Tuberculosis yes o no o
8) Have you/are you taking bisphophonates? (ex. Fosamax, Actonel, Boniva, Aredia, Zometa, Skelid, Didronel, Reclast) yes o no o

Do you *now have* or have you *ever had* any of the following cardiovascular diseases?
Check any that apply:

o Heart disease
o Heart attack
o Coronary bypass. Date of surgery _____
o Angina
o Mitral valve prolapse/Heart murmur
o Family history of cardiovascular disease
o Rheumatic fever or rheumatic heart disease
o Congenital heart defects/heart valve deficiency
o Prosthetic (artificial) heart valves
o Pacemaker. Date of placement _____
o High cholesterol
o Shortness of breath after mild exercise
o Shortness of breath when you lie down
o Swelling of ankles
o Chest pain upon exertion
o Abnormal bleeding or extended clotting time
o Frequent or unexpected nose bleeds
o Hardening of the arteries
o High blood pressure
o Low blood pressure
o Stroke
o Stents. Date of placement _____
o Congestive heart failure
o NONE

Continue to check any that apply:

o Hay fever/Sinusitis
o Alzheimer's
o Anemia
o Angina
o Asthma
o Arthritis
o Autoimmune
o Blood Disorder
o Cancer
o Chemo Therapy
o Radiation Treatment
o Chronic Sinus
o Cirrhosis
o Depression
o Anorexia/Bulimia
o Drug Treatment
o Epilepsy/Seizures
o Glaucoma
o Heart Disease
o Hemophilia
o Herpes
o AIDS
o Jaundice
o Joint Replacement
o Lung Disease
o Kidney Disease
o Organ Transplant
o Osteoporosis
o Parkinson's
o Gastric Reflux
o Indigestion
o Severe Headaches
o Sexually Transmitted Disease
o Skin Problems
o Tuberculosis
o Stomach Ulcers
o NONE

Patient/Guardian Signature **Date**

HEALTH HISTORY PAGE 2

	Yes	No
Do you consider yourself currently under an abnormally high amount of stress?	o	o
Have you had any unexplained or un-planned weight loss recently?	o	o
Do you now or have you ever smoked?	o	o
If you currently smoke, how much? _____		
If you were a smoker, when did you quit? _____		
Do you chew tobacco?	o	o
If yes, how often? _____		
Do you drink alcohol?	o	o
If yes, how much? ____ /week		
□ Less than 1 per week		

Are you *ALLERGIC* to anything? Yes 0 No 0
If yes, check any that apply:
(get hives, a rash, have trouble breathing, etc.):
o Antibiotics (penicillin, tetracycline, etc.)
o Local dental anesthetics
o Codeine
o Aspirin
o Barbiturates or sedatives
o Latex
o Others - List _____

	Yes	No
Have you ever had an adverse reaction (nausea, dizziness) with any drug or medication?	o	o
Do you have any disease, condition or medical problem not listed you feel we should know about?	o	o

W O M E N O N L Y

	Yes	No		Yes	No
Are you currently pregnant?	o	o	Do you have regular gynecological exams?	o	o
If yes, expected delivery date _____			Have you reached menopause?	o	o
Are you nursing?	o	o	Are you on hormone replacement therapy?	o	o
Are you taking birth control pills?	o	o			

Are you *currently* taking medication? o yes o no
If yes, please check any of the following that you are *currently* taking:

o Antibiotics
o Antidepressants (Prozac, Zoloft, etc.)
o Antihistamines
o Blood pressure medication
o Blood thinners
o Cortisone (Prednisone)
o Cholesterol medication
o Decongestants
o Diuretics (water pills)
o Hormones (birth control, estrogen)
o Inhalants
o Insulin
o Heart medication/nitroglycerin
o Muscle relaxants
o Pain medication (Aspirin, Advil, Lortab, etc.)
o Sleeping pills
o Thyroid medication
o Tranquilizers
o Vitamins
o Herbal supplements

List the names of all medications you are currently taking:

Name	Name

(office use only)

Today's Date____/____/____

BP _____ PULSE _____

02_____ Med consult requested **O**
Notes:

Dr. Signature _____

Patient/Guardian Signature **Date**