HEALTH HISTORY

Name _____ Date of Birth: _____

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:_____

Please list names, phone numbers and specialty of all physicians who are currently treating you:

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.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Blood Transfusion	No	Yes	Drug Addiction	No	Yes
Cancer or Tumor?	No	Yes	Mental Health Disorder	No	Yes
Diabetes	No	Yes	Alzheimer's Disease	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Dementia	No	Yes
Epilepsy/Seizures	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Rheumatic Fever	No	Yes
Glaucoma	No	Yes	Rheumatic Heart Disease	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Immune System Disorder	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Pacemaker	No	Yes	Genital Herpes	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Stent? When placed?	No	Yes	Hypoglycemia	No	Yes
Angina/Chest Pain	No	Yes	Sleep Apnea	No	Yes
Stroke	No	Yes	CPAP Machine	No	Yes
Acid Reflux/GERD	No	Yes			

Other conditions or comments:

_____

_____

Do you need an antibiotic before dental treatment?	No	Yes
Are you taking a blood thinner such as Coumadin® or Plavix® (including daily aspirin)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®? If so, when did the treatment begin? When did the treatment end?	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

Abnormal Blood Pressure? (Please circle) No Yes
Have you ever received a diagnosis of "high blood pressure"?
What is your normal blood pressure? S /D Today: _____/_____

Are you allergic or have you had a reaction to: (Type of reaction)

a. Local anesthetics ……... No Yes _____
b. Penicillin or other antibiotics …… No Yes _____
c. Aspirin, Ibuprofen or Tylenol…… No Yes _____

d. Codeine, Valium® or other sedatives……. No Yes _____
e. Latex…….. No Yes _____
f. Metals……..... No Yes _____
g. Acrylic…… No Yes _____
h. Other (please specify)_____

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

List all **Medications** you are currently taking:
Prescription, **Over-the-counter** medications (ex. Aspirin, antacids), **Vitamins** and **Herbals** (ex. Ginseng). Please indicate medications **taken as needed** (ex. Nitroglycerin)

Date Started	Name of Medication/Dose	How Often?	Reason for Taking?

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 Signature *Date*

_____ _____
Reviewed by *Date*

DOCTOR'S USE ONLY: ASA I II III IV
Comments on patient interview concerning medical history:
_____
_____
_____