HEALTH HISTORY

Patient _____ _____ Date_____
First Last

DOB _____ MALE_____ FEMALE_____ OTHER _____ Preferred Name_____

Are you in good health?.....Y___N___
Has there been any change in your general health in the past 5 years?..... Y___N___
Date of last physical examination: _____
Are you under the care of a physician for a particular problem?.....Y___N___
If so, Physician's name and phone number_____
Have you ever had any serious illnesses, operations, or hospitalizations?.....Y___N___
If so, please describe:

Are you using any of the following medications?

Antibiotics……..Y___ N___
Steroids……...Y___N___
Blood thinners….Y___ N___
Tranquilizers……Y___N___
Aspirin or Ibuprofen ……Y___ N___
Insulin/Oral diabetes meds...Y___N___
High blood pressure……..Y___ N___
Heart medications……Y___N___

Are you using or have you used in the past …… Fosamax or similar……...Y___ N___

*Please list ALL medications and doses, including prescriptions, over the counter medications, herbal remedies, vitamins, etc…

Are you taking Coumadin (Warfarin) ? Y____ N____

Are you allergic or have you had an adverse reaction to:

Local anesthesia ……..Y___N___
Latex/rubber products …….Y___N___
Penicillin or other antibiotics...Y___N___
Sulfites…….Y___N___
Sedatives or barbiturates……..Y___N___
Dairy…….....Y___N___
Aspirin or Ibuprofen…….....Y___N___
Nuts……Y___N___
Codeine or other pain killers…..Y___N___
Other _____

Do you smoke or chew tobacco?.....Y___N___
Is there any past or current history of alcohol, chemical dependency or emotional disorder that may affect the care we provide you?.....Y___N___
Have you ever had any serious problems with any previous dental treatment?.....Y___N___

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

Rheumatic fever or rheumatic heart disease……..……. Y___N___
Congenital heart disease……..... Y___N___
Cardiovascular disease:(**circle which one**: **heart attack, murmur, coronary artery disease**, ……. Y___N___
angina, stroke, high blood pressure, palpitations, heart surgery, pacemaker)
Lung disease: (**circle which one**: **asthma, emphysema, chronic cough, bronchitis,** ……... Y___N___
tuberculosis, shortness of breath, chest pain, severe coughing)
Seizures, convulsions, epilepsy, fainting or dizziness…….…..… Y___N___
Bleeding disorder, anemia, bleeding tendency…….……...….. Y___N___
Do you bruise easily? …….…….. Y___N___
Liver disease (jaundice, hepatitis)circle which one…..……...…….. Y___N___
Kidney disease……... Y___N___
Diabetes…… Y___N___
Thyroid disease…….. Y___N___
ADHD or ADD…….. Y___N___
Arthritis…….. Y___N___
Stomach ulcers or colitis……..... Y___N___
Glaucoma……... Y___N___
Implants placed anywhere in your body(circle which one:pacemaker, heart valve, knee, hip) ……... Y___N___
Radiation treatment or chemotherapy……...…… Y___N___
Clicking or popping of jaw joint, pain near ear, difficulty opening mouth……...…… Y___N___
Grind or clench teeth……..... Y___N___
Sinus or nasal problems……...…….. Y___N___
Any disease, drug or transplant operation that has depressed your immune system……...……. Y___N___
Do you have any other disease, condition or problem not listed above that……..….... Y___N___
you think the doctor should know about?
Please explain if YES:

Do you wish to speak privately to the doctor about anything?..... Y___N___

I understand the importance of a truthful Health History in assisting the doctor in providing
the best care possible……..….. Y___N___

FOR WOMEN ONLY:
Are you pregnant, or is there any chance you might be pregnant?..... Y___N___
Are you nursing?..... Y___N___

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. Please consult with your physician for further guidance.

_____	_____	_____
Date	Patient/Guardian Signature	Doctor/Hygienist initials