HEALTH HISTORY

*PLEASE FILL OUT ALL FORMS
AND SIGN THE HIGHLIGHTED AREAS

Patient's Name Date of Birth Today's Date

Please Answer all questions by circling Yes (Y) or No (N) ***All responses are kept confidential***

1. Are you in good health? .....Y N
2. Has there been any change in your general health in the past year? .....Y N
3. Date of last physical exam/Dr's name/phone _____
4. Are you now under a physician's care for a particular problem? .....Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe:.....Y N

   _____

   _____
6. Height _____ Weight _____
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease?.....Y N
   - B. Congenital Heart Disease? .....Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) .....Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? .....Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness.....Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily?.....Y N
   - G. Liver Disease (Jaundice, Hepatitis)?.....Y N
   - H. Kidney Disease? .....Y N
   - I. Diabetes?.....Y N
   - J. Thyroid Disease (Goiter)?.....Y N
   - K. Arthritis?.....Y N
   - L. Stomach Ulcers or Colitis?.....Y N
   - M. Glaucoma?.....Y N
   - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? .....Y N
   - O. Radiation (X-ray) treatment for Cancer? .....Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? .....Y N
   - Q. Sinus or Nasal problems?.....Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system? .....Y N
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics?.....Y N
   - B. Anticoagulants (Blood Thinners)? .....Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen?.Y N
   - D. High Blood Pressure medications? .....Y N
   - E. Steroids (Cortisone, etc.)? .....Y N
   - F. Tranquilizers .....Y N
   - G. Insulin or Oral Anti-Diabetic drugs? .....Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
   - I. Are you taking or *have you ever taken* Bisphosphonates (Fosamax or Actonel for osteoporosis, or chemotherapy for multiple myeloma, etc.) ? .....Y N
   - J. Please list any and all medications taken, including prescription medications, over-the-counter mediations, herbal or holistic remedies, vitamins or minerals:_____

     _____

     _____
9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)? .....Y N
   - B. Penicillin or other antibiotics? .....Y N
   - C. Sedatives, Barbiturates?.....Y N
   - D. Aspirin or Ibuprofen?.....Y N
   - E. Codeine or other pain killers? .....Y N
   - F. Latex or Rubber Products? .....Y N
   - G. Other allergies or reactions? Please, list.....Y N

     _____

     _____
10. Do you smoke or chew Tobacco?.....Y N
    How much per day? _____
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you?.....Y N
12. Have you had any serious problems associated with any previous dental treatment?.....Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia?.....Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? .....Y N
15. Do you wish to talk to the doctor privately about anything? .....Y N
16. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **<u>is there any chance</u>** 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.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible and that I will have the opportunity to discuss my Health History with my doctor during this appointment.

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

Medical Update: I have read my Health History dated _____ and confirm that it adequately states past and present conditions.

Date _____ Exceptions or changes _____ Patient's Signature _____ Doctor's Initials _____

Date _____ Exceptions or changes _____ Patient's Signature _____ Doctor's Initials