HEALTH HISTORY FORM

Name _____ **Date** _____

Date of last health care exam: _____ **What was this exam for?** _____

Have you been hospitalized or had surgery? (Please circle) No Yes

If yes,
reason: _____

Are you currently receiving care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

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.

Blood Disorders?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism, or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma, COPD or other Lung Diseases	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Psychiatric Therapy	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Renal Dialysis	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery, Angina	No	Yes	Other Conditions	No	Yes
Heart Stent? When placed?	No	Yes	Recurrent Illnesses	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Biaxin® (clarithromycin)	No	Yes
Antacids?	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Barbiturates (any)	No	Yes
Dilantin® or Tegretol®	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®, RECLAST) or PROLIA? If so, when did the treatment begin? When did the treatment end?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

Please list any medications you are currently taking and dosages:

1) _____ 2) _____

3) _____ 4) _____

5) _____ 6) _____

7) _____ 8) _____

Please list any dietary or herbal supplements you are taking, and for what purpose:

1) _____ 2) _____

3) _____ 4) _____

5) _____ 6) _____

Do you use recreational drugs?____ If so, which ones? _____

Sleep:

1) Do you suspect or have you been told that you snore?
2) Do you suspect or have you been diagnosed with sleep apnea?
3) Are you being treated for sleep apnea with a CPAP, BiPAP, or other device?

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" or "low blood pressure"?

What is your normal blood pressure? S /D Today: _____/_____

Are you allergic or have you had a reaction to:

a) Local anesthetics or epinephrine..... No Yes
b) Penicillin or other antibiotics ..... No Yes
c) Aspirin, Ibuprofen or Tylenol® ..... No Yes
d) Codeine, Valium®, Hydrocodone, Oxycodone or other sedatives..... No Yes
e) Latex or Metals No Yes

f) 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

Weight and Diet considerations

Weight	Height	Meals per Day	Dietary Restrictions	Food Allergies
Sugar in your diet (circle one): *none* *slight* *moderate* *high*				

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

_____

_____

Significant findings from questionnaire or oral interview:

_____

_____

Dental management considerations:

_____

_____

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 any change in my health and medication.

Patient (Print Name)	*Patient Signature*	*Date*
Doctor (Print Name)	*Doctor Signature*	*Date*