HEALTH HISTORY

Name _____ Date _____

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:_____

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. _____

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.

Heart Murmur (mitral valve prolapse)	No	Yes	Psychosis	No	Yes
Anemia	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Slow-Healing Mouth Sores	No	Yes
Hepatitis, Any Form	No	Yes	Other Infections	No	Yes
Rheumatic Fever	No	Yes	Recurrent Illnesses	No	Yes
Asthma	No	Yes	Joint Replacement	No	Yes
HIV Positive or AIDS Related Complex	No	Yes	Glaucoma	No	Yes
Emphysema or other Respiratory Illnesses	No	Yes	Abnormal Bleeding from a cut	No	Yes
Abnormal Heart or Previous Endocarditis	No	Yes	Liver Disease (including Jaundice)	No	Yes
Heart Disease/ Surgery/Attack/ Stent Placed	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Kidney Disease	No	Yes	Latex Sensitivity	No	Yes
Venereal Disease	No	Yes	Sleep Apnea	No	Yes
Tuberculosis	No	Yes			

Do you have a medical need for pre-medication for dental treatment? 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 any form of birth control? (pills, patch or implant) No Yes

Abnormal Blood Pressure? (Please circle) No Yes
If yes, what is it usually: _____/_____

Are you allergic or have you had a reaction to:

a. Local anesthetics ……... No Yes
b. Penicillin or other antibiotics …… No Yes
c. Aspirin ……..……... No Yes
d. Codeine, valium or other sedatives……..… No Yes
e. Other _____

Have you traveled outside of the US in the last 30 days? No Yes
If "yes" where _____

Are you a smoker? User of smokeless tobacco (chewing tobacco)? No Yes
If so, how much do you smoke / use per day? _____

Please list any medications you are currently taking and dosages:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes

Are you taking Tagamet (Cimetidine)? No Yes If yes, how often? _____

Do you take Antacids? No Yes If yes, how often? _____

Are you taking any herbal supplements/medicines? No Yes If yes, which ones?_____

Diet: Restricted Diet _____
How many meals a day _____
Food Allergies _____
Sugar in your diet: ❑ None ❑ Slight ❑ Moderate ❑ High

Have you ever taken any drugs for bone loss? No Yes If yes what medication?_____

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 (Print Name) *Patient Signature* *Date*

DR. USE ONLY: **ASA I II III IV**