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 or have had a physical within the past 2 years? 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. ____

Acid Reflux	No	Yes	Heart Stent When placed?	No	Yes
Angranulocyctosis	No	Yes	Hepatitis, Any Form	No	Yes
Anemia or Blood Disorder	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Arthritis, Rheumatism or other inflammatory disease	No	Yes	Joint Replacement When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut	No	Yes	Liver Disease (including Jaundice)	No	Yes
Blood Disorder	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Cancer or Tumor	No	Yes	Osteoporosis	No	Yes
Diabetes I or II	No	Yes	Pace Maker	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Previous Biopsies	No	Yes
Epilepsy/Seizures	No	Yes	Psychosis	No	Yes
Fainting or Dizzy Spells	No	Yes	Radiation or Chemo Treatment	No	Yes
Glaucoma	No	Yes	Recurrent Illnesses	No	Yes
Head Injury	No	Yes	Sinus Problems	No	Yes
High Blood Pressure, Hypertension	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Stomach Problems	No	Yes
Congenital Heart Disease	No	Yes	Stroke	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	Tuberculosis	No	Yes
Heart Valve Disfunction	No	Yes	Ulcers	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Unintentional Weight Loss/Gain	No	Yes

Other conditions or surgeries not listed above?

Please explain:____

Do you need to take an antibiotic before dental care? No / Yes

SPECIFIC MEDICATIONS			Tagamet® (cimetidine) or Prilosec® (omeprazole)	No	Yes
Antacids	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)	No	Yes
Dilantin® or Tegretol®	No	Yes	Serzone® (nefazodone)	No	Yes
Barbiturates (any)	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
St. John's Wort or Kava-Kava	No	Yes	Biaxin® (clarithromycin)	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
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

Please list any medications you are currently taking and dosages:

1.______________________________________ 5.______________________________________

2.______________________________________ 6.______________________________________

3.______________________________________ 7.______________________________________

4.______________________________________ 8.______________________________________

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

1.______________________________________ 4.______________________________________

2.______________________________________ 5.______________________________________

3.______________________________________ 6.______________________________________

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

Are you allergic or have you had a reaction to:

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. Other (please specify)____

Do you use tobacco? If yes, smoke or chew How much per day? For how long?	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

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 changes in my health and medication.

____________________________ ____________________________ ____________________

Patient / Legal Guardian (Print Name) Patient / Legal Guardian Signature Date

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

____

Significant findings from questionnaire or oral interview

____

Dental management considerations:

____

REVIEWED BY:

FRONT DESK: ___________

ASSISTANT: _____________

DR/HYG: ________________