

## 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. \_\_\_\_\_
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.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Stroke	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Psychosis (Depression, etc.)	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy	No	Yes
Fainting or Dizzy Spells	No	Yes	Rheumatic Fever	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Blood Thinners including Aspirin	No	Yes
Heart Murmur	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Osteoporosis (any form)	No	Yes
Headache/Miagraines	No	Yes	Other Conditions What?	No	Yes
Thyroid	No	Yes	Recurrent Illnesses What?	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	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?				No	Yes
				When did the treatment end?	
Have you ever taken any prescription drugs such as fen-phen for weight loss?				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. _____ |

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"?

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 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?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

Weight and Diet considerations

Weight	Height		

*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 Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Doctor Signature*

\_\_\_\_\_  
*Date*

Pharmacy Information:

\_\_\_\_\_  
 Name and Location

\_\_\_\_\_  
 Phone Number