HEALTH HISTORY

Patient Name: _____ **DOB:** _____ **Height:**_____ **Weight:** _____

Answer all questions by circling Yes (Y) or No (N) and provided details as requested.

- Are you in good health……**Y** / N
- Has there been any change in your general health in the last year? ……Y / N
  If Yes, please describe_____
  _____
- Have you been told by any physician that you need to take a pre-medication before dental treatment…… Y / N
  If so, for what condition? _____

Do you have or have ever been diagnosed with any of the following? If yes please circle type (s) ….

- Rheumatic Fever or Rheumatic Heart Disease…… Y / N
- Congenital Heart Disease……. Y / N
- Cardiovascular Disease…… Y / N
  (Heart Attack, Heart Murmur, Coronary Artery Disease, Angina, HBP, Stroke, Palpitations, A-fib, Heart Surgery, Pacemaker, valve replacement)
- Lung Disease…… Y / N
  (Asthma, Emphysema, COPD, Chronic Cough, Current / Chronic Bronchitis, Severe Cough, Shortness of Breath, Tuberculosis)
- Sinus or Nasal problems…… Y / N
  (If yes: _____)
- High Cholesterol…… Y / N
- Seizures, Convulsions or Epilepsy…… Y / N
- Vertigo, Fainting or POTS…… Y / N
- Bleeding Disorder…… Y / N
  (Anemia, Spontaneous Bruising, Hemophilia, Excessive Bleeding Tendency)
- Liver Disease…… Y / N
  (Jaundice, Hepatitis, Cirrhosis, Heavy Metals)
- Kidney Disease…… Y / N
  (Kidney Stones, Chronic KD, Chronic UTI, PCKD)
- Diabetes …… Y / N
  (Type I or Type 2)
- Thyroid Disease …… Y / N
  (Hyperthyroidism, Hypothyroidism, Goiter, Graves)
- Arthritis …… Y / N
  (Osteoarthritis, Rheumatoid, Ankylosing Spondylitis, Psoriatic)
- Osteoporosis or Osteopenia…… Y / N
- Gastrointestinal Issues…… Y / N
  (GERD / Acid Reflux, Ulcers, Colitis, IBS, Celiac, Crohn's, Diverticulitis)
- Current / Previous, Radiation or Chemotherapy …… Y / N
- Artificial Implants anywhere in your body…… Y / N
  (Heart Valve, Stent, Hip, Knee, Other Joint, Shunt, Port)
- Any Disease, Drug or Transplant operation that has suppressed your immune system…… Y / N
  (If Yes:_____)
- Jaw joint issues…… Y / N
  (Clicking or Popping of Joint, Grinding, Clenching, Pain near ear, difficulty opening mouth)
- Snore…… Y / N
- Prior Sleep Study…… Y / N
  If so, were you diagnosed with Sleep Apnea …… Y / N

Are you using any of the following?

- Antibiotics…… Y / N
- Blood Thinners (anticoagulants)…… Y / N
- Blood Pressure Medication…… Y/ N
- Steroids (cortisone, prednisone)…… Y/ N
- Tranquilizers …… Y N
- Insulin or Diabetic Medication…… Y / N
- Digitalis, Inderal, Nitroglycerine…… Y / N
- NSAIDS, Aspirin, Motrin, Aleve, Ibuprofen…… Y / N

Please list all medications, supplements, vitamins/ minerals, OTC medications and herbs.

_____
_____
_____
_____
_____

Are you taking or have you ever taken Bisphosphonates for osteoporosis, multiple myeloma, etc. …… Y / N
If yes, please circle; Reclast, Fosamax, Actonel, Bomiva, Arendia, Zometa or Prolia

Are you allergic to, or have you had an adverse reaction to: List

- Local Anesthesia (Novocain)…… Y / N
- Penicillin or Amoxicillin…… Y / N
- Other Antibiotic _____ Y / N
- Sedatives or Barbiturates…… Y / N
- Aspirin or Ibuprofen…… Y / N
- Codeine or other painkiller _____ Y / N
- Latex or Rubber…… Y / N
- Dyes …… Y / N
- Metal or Jewelry_____ Y / N
- Food _____ Y / N
- Other Allergies, please list
- _____
  _____

Additional Information

- Do you use Cigarettes, Vape or Chew Tobacco…… Y / N
  How much per day? _____
- Do you have past history of Alcohol / Chemical dependency that may affect the care we give you…… Y / N
- Have you had any serious problems associated with any previous dental treatment?…… Y / N
- Do you have any other disease, condition or problem not listed above that you think the doctor should know about? …… Y/ N
- Do you wish to talk to the doctor privately…… Y /N

For biologically Female Patients:

- Are you pregnant, or is there any chance you might be pregnant …… Y / N
- Are you nursing…… Y / N

Chief Dental Concern:

_____
_____
_____

Other concerns you wish to share:

_____
_____

I understand the importance of complete and truthful Health History to assist my dentist in providing the best possible care. I have completed this form as accurately as I am able and have provided complete and accurate information. Any questions I had about this form have been explained to my satisfaction.

_____

Patient Signature:

Date: _____