HEALTH HISTORY

Patient's Name | Date of Birth | Height | Weight | Date

Answer all questions by circling Yes (Y) or No (N) All responses are kept confidential

1. Are you in good health? .... Y N
2. Has there been any change in your general health in the past year? .... Y N
3. Date of last physical exam ____________
4. Are you now under a physician's care for a particular problem? If so, describe: .... Y N
   ____
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe: .... Y N
   ____
6. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? .... Y N
   - B. Congenital Heart Disease? .... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? .... Y N
   - D. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Current Bronchitis, Current Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? .... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness? .... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? .... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? .... Y N
   - H. Kidney Disease? .... Y N
   - I. Diabetes? .... Y N
   - J. Thyroid Disease (Goiter)? .... Y N
   - K. Arthritis? .... Y N
   - L. Stomach Ulcers or Colitis? .... Y N
   - M. Glaucoma? .... Y N
   - N. Osteoporosis? .... Y N
   - O. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? .... Y N
   - P. Radiation (X-ray) treatment for Cancer? .... Y N
   - Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
     Snore? .... Y N
     Prior Sleep Study? .... Y N
   - R. Sinus or Nasal problems? .... Y N
   - S. Any disease, drug or transplant operation that has depressed your immune system? .... Y N
7. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? .... Y N
   - B. Anticoagulants (Blood Thinners)? .... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
   - D. High Blood Pressure medications? .... Y N
   - E. Steroids (Cortisone, Prednisone, etc.)? .... Y N
   - F. Tranquilizers? .... Y N
   - G. Insulin or Oral Anti-Diabetic drugs? .... Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
   - I. Are you taking or ***have you ever taken*** Bisphosphonates for osteoporosis, multiple myeloma or other cancers? If so, please circle (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia) .... Y N
   - J. Have you ever been advised not to take a medication? .... Y N
   - K. Please list any and all current medications, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals: ____________
     ____
8. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novacain, etc.)? .... Y N
   - B. Penicillin or other antibiotics? .... Y N
   - C. Sedatives, Barbiturates? .... Y N
   - D. Aspirin or Ibuprofen? .... Y N
   - E. Codeine or other pain killers? .... Y N
   - F. Latex or Rubber products? .... Y N
   - G. Metal of any kind? .... Y N
   - H. Chemicals or jewelry (rash or sensitivity)? .... Y N
   - I. Food products? .... Y N
   - J. Other allergies or reactions? Please list .... Y N
     ____
     ____
9. Do you smoke or chew Tobacco? .... Y N
   How much per day? ________
10. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? .... Y N
11. Have you had any serious problems associated with any previous dental treatment? .... Y N
12. Have you or an immediate family member had any problem associated with intravenous anesthesia? .... Y N
13. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? .... Y N
14. Do you wish to talk to the doctor privately about anything? .... Y N
15. Have you ever had a bone density scan? .... Y N
16. **FOR WOMEN ONLY**
   - A. Are you Pregnant, or **is there any chance** you might be Pregnant? .... Y N
   - B. Are you nursing? .... Y N
   - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

Chief Dental Concern: ____________

Other Concerns my Dentist needs to know: ____________

I HAVE READ AND UNDERSTAND THE ABOVE. ANY QUESTIONS I HAD ABOUT THIS FORM HAVE BEEN ANSWERED AND I UNDERSTAND THE ANSWERS. I UNDERSTAND IT IS MY RESPONSIBILITY TO FILL OUT THE FORM CORRECTLY AND COMPLETELY. I understand the importance of a truthful and complete Health History to assist my dentist in providing the best care possible. I have had the opportunity to discuss my Health History with my dentist.

Date: ____________ Patient's Signature: ____________

Patient's Name	Date of Birth	Height	Weight	Date

STOP-BANG

S	**Snoring**	Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	YES	NO
T	**Tired**	Do you often feel tired, fatigued, or sleepy during daytime?	YES	NO
O	**Observed**	Has anyone observed you stop breathing during your sleep?	YES	NO
P	**Pressure**	Do you have or are you being treated for high blood pressure?	YES	NO
B	**BMI**	Is your BMI more than 35? BMI = mass in lb/height in inches ^{2} X 703	YES	NO
A	**Age**	Is your age over 50 years?	YES	NO
N	**Neck**	Is your neck circumference greater than 17" (men) or 16" (women)?	YES	NO
G	**Gender**	Is your gender male?	YES	NO

High risk of OSA: answering yes to 3 or more items.
Low risk of OSA: answering yes to 2 or fewer items

The STOP-BANG Questionnaire is a concise and easy to-use, evidence-based, screening tool for clinics. Combined with body mass index, age, neck size, and gender (B.A.N.G.), it had a high sensitivity, especially for patients with moderate to severe OSA.

Epworth Sleepiness Scale

0 = would never doze **1** = slight chance of dozing **2** = moderate chance of dozing **3** = high chance of dozing

SITUATION	CHANCE OF DOZING			
Sitting and Reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (movie theatre or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talk to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3
TOTAL:	_______			

A score of 10 or more is considered *sleepy.*

A score of 18 or more is considered *very sleepy.*

Date: ____________________ Patient's Signature: ____

FOR COMPLETION BY THE DOCTOR

Comments on patient interview concerning medical history: ____
____

Significant findings from questions or oral interview: ____
____

Dental Management Considerations: ____
____

Date: ____________________ Dentist's Signature: ____