HEALTH HISTORY

Patient's Name _____ 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? Y N
5. Have you ever had any serious illnesses, operations or hospitalizations? If so, describe Y N

   _____

   _____
6. Height _____ Weight _____
7. DO YOU HAVE OR HAVE YOU EVER HAD:

Rheumatic Fever of Rheumatic Heart Disease?	Y N
Congenital Heart Disease?	Y N
Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?)	Y N
Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing?)	Y N
Seizures, Convulsions, Epilepsy, Fainting, Dizziness, Psychiatric Treatment, or other Nervous Disorder?)	Y N
Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily?	Y N
Liver Disease? (Jaundice, Hepatitis)?	Y N
Kidney Disease?	Y N
Diabetes?	Y N
Thyroid Disease (Goiter?) Parathyroid	Y N
Arthritis?	Y N
Stomach Ulcers or Colitis?	Y N
Glaucoma?	Y N
Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee?)	Y N
Venereal or Herpes?	Y N
Radiation or treatment for Cancer?	Y N
Clicking or popping of jaw joint, pain near ear, Difficulty opening mouth, grind or clench teeth?	Y N
Sinus or Nasal problems?	Y N
Any disease, drug or transplant operation that Has depressed your immune system?	Y N
HIV, AIDS, or ARC	Y N

8. 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
   - F. Tranquilizers? Y N
   - G. Insulin or Oral Anti-Diabetic drugs? Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
   - I. Any regular prescription medicine, pills or drugs Y N
     If Yes, please list: _____

     _____
   - J. Herbal or Holistic remedies, Vitamins or over-the-counter medications? Y N
     If Yes, please list: _____

     _____

9. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ALLERGIC REACTION TO:
   - A. Local Anesthesia (Novocain, etc.?) Y N
   - B. Penicillin or other antibiotics? Y N
   - C. Sedatives, Barbiturates? Y N
   - D. Aspirin Ibuprofen? Y N
   - E. Codeine or other pain killers? Y N
   - F. Latex or Rubber Products? Y N
   - G. Other allergies or reactions? (sulfa or Iodine) Y N

     Please list _____
10. Do you smoke or chew Tobacco? Y N
    How much per day? _____
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? Y N
12. Have you had any serious problems associated with any previous dental treatment? Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia? Y N
14. Do you have any other disease, condition, or problem not listed above that you think the doctor should know about? Y N
15. Steroids (Cortisone, etc?) Y N
16. Do you wish to talk to the doctor privately about anything? Y N
17. FEMALES ONLY
    - A. Are you Pregnant, or <u>is there any chance</u> that 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 or 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.

What is your chief Oral or Dental problem today?_____

_____

Have you ever had any serious trouble with any previous dental treatment? _____

_____

_____

For Completion by Dentist

_____

Significant findings from questionnaire or oral interview: _____

_____

Comments on patient interview concerning medical history: _____

_____

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the Opportunity to discuss my Health History with my doctor.

_____	_____	_____
Date	Signature of Person Completing Health History	Doctor's Initials

_____

Medical Update: I have read my Health History dated _____ and confirm that it adequately states past and present conditions.

_____	_____	_____	_____
Date	Exceptions or changes	Patient's Signature	Doctor's Initials
_____	_____	_____	_____
Date	Exceptions or changes	Patient's Signature	Doctor's Initials