# HEALTH HISTORY

Date: _____

Health problems you have or medications you may be taking can sometimes affect the dental treatment you receive in our office. As required by law, our office adheres to policies to protect the privacy of information we receive, create or maintain. Any information provided below is for our records only and will be kept confidential. In addition to completing this form, you may be asked additional questions that pertain to your treatment. This office does not use this information to discriminate. Thank you for completing this form.

Name: _____ Preferred Name: _____
FIRST MI LAST

D.O.B.: _____ Age: _____ Phone: _____ Sex: ___Male ___Female

If you are completing this form for another person: _____
NAME RELATIONSHIP

## *ALLERGIES*

Are you allergic to or have you had a reaction to any of the following. If YES, please give further details.

| | | | | | |
|---|---|---|---|---|---|
| Latex: ……..…… | O YES | O NO | Aspirin: ……..... | O YES | O NO |
| Penicillin: ……..….. | O YES | O NO | Advil/Ibuprofen/NSAIDS: …… | O YES | O NO |
| Other Antibiotics: …… | O YES | O NO | Metals: …… | O YES | O NO |
| Sulfa Drugs: ..…… | O YES | O NO | Food: …… | O YES | O NO |
| Codeine or other Narcotics: ……..… | O YES | O NO | Other: ……..….. | O YES | O NO |
| Local Anesthetics: …… | O YES | O NO | ……..….. | | |

## *MEDICATIONS*

Please list any prescription or over the counter medications, vitamins, or natural supplements that you are currently taking or have been prescribed. If more space is necessary, please attach a separate piece of paper.

_____ _____

_____ _____

## *DENTAL INFORMATION*

| | | | | | |
|---|---|---|---|---|---|
| Do your gums bleed when brushing or flossing?……..…. | O YES | O NO | Do you have any popping, discomfort, etc. in your jaw? ……..... | O YES | O NO |
| Are your teeth sensitive? ……..…… | O YES | O NO | Do you have sores or ulcers in your mouth? | O YES | O NO |
| If YES, please explain: ……..... | | | Do you participate in contact sports? …..... | O YES | O NO |
| Does food or floss catch between your teeth? ……..... | O YES | O NO | Have you ever had a serious injury to your head or mouth? ……. | O YES | O NO |
| Have you ever had periodontal (gum) treatments? ……. | O YES | O NO | Have you ever had orthodontic (braces) treatment? …….. | O YES | O NO |
| Is your mouth dry? ……..….. | O YES | O NO | Are you on well water? ……..…….. | O YES | O NO |
| Are you currently experiencing dental pain or discomfort? ..... | O YES | O NO | Have you ever had problems with previous dental treatment? …….. | O YES | O NO |
| Do you clench or grind your teeth? ...…… | O YES | O NO | If YES, please explain: …… | | |

What is the reason for today's dental visit? ……

How do you feel about your smile? ……

## *MEDICAL INFORMATION*

| | | | | | |
|---|---|---|---|---|---|
| Total Joint Replacement: …….. | O YES | O NO | Artificial (prosthetic) heart valve: ……..... | O YES | O NO |
| Joint(s): ……..…… | | | Previous infective endocarditis: …….. | O YES | O NO |
| Date: …… | | | Damaged valves in transplanted heart: ……. | O YES | O NO |
| Any Complications: …… | | | | | |
| Have you been treated with or are you scheduled to be treated with: | | | Congenital heart disease (CHD) | | |
| Fosamax ® (alendronate) …… | O YES | O NO | Unrepaired, cyanotic CHD …… | O YES | O NO |
| Actonel ® (risedronate) ….…….. | O YES | O NO | Repaired in last six months ……..… | O YES | O NO |
| Aremedia ® (I.V. bisphosphonate) ……..... | O YES | O NO | Repaired CHD with residual defects …… | O YES | O NO |
| Zometa ® (I.V. bisphosphanate) …… | O YES | O NO | Are you taking Cortisone/Prednisone ®? ……. | O YES | O NO |
| | | | Have you taken Cortisone/ Prednisone ® in the last month? ……..... | O YES | O NO |
| Date treatment began: …… | | | Have you ever taken antibiotics prior to dental treatment? ..... | O YES | O NO |

PLEASE CONTINUE ON THE BACK SIDE OF THIS FORM.

Please fill out the following section for your medical history.

Physician Name: _____ Location: _____ Date of Last Exam: _____

| | | | | | |
|---|---|---|---|---|---|
| Acid reflux/ persistent heartburn | O YES | O NO | Chronic pain | O YES | O NO |
| Active Tuberculosis | O YES | O NO | Diabetes type I or II | O YES | O NO |
| AIDS or HIV infection | O YES | O NO | Eating disorder | O YES | O NO |
| Arthritis | O YES | O NO | Epilepsy | O YES | O NO |
| Autoimmune disease | | | Fainting spells or seizures | O YES | O NO |
| Rheumatoid arthritis | O YES | O NO | Gastrointestinal disease | O YES | O NO |
| Systemic lupus erythematosus | O YES | O NO | Glaucoma | O YES | O NO |
| Other: | O YES | O NO | Liver Disease | | |
| Bleeding disorder | | | Hepatitis A | O YES | O NO |
| Anemia | O YES | O NO | Hepatitis B | O YES | O NO |
| Bruise easily | O YES | O NO | Hepatitis C | O YES | O NO |
| Clot Easily | O YES | O NO | Cirrhosis | O YES | O NO |
| Hemophilia | O YES | O NO | Jaundice | O YES | O NO |
| Explain | O YES | O NO | Other: | O YES | O NO |
| Blood transfusion | O YES | O NO | Hypoglycemia | O YES | O NO |
| Breathing Problems/Lung Disease | | | Kidney problems | | |
| Asthma | O YES | O NO | Renal dialysis | O YES | O NO |
| Bronchitis | O YES | O NO | Other: | O YES | O NO |
| COPD | O YES | O NO | Malnutrition | O YES | O NO |
| Cough that produces blood | O YES | O NO | Mental health disorders | O YES | O NO |
| Emphysema | O YES | O NO | If YES: | | |
| Persistent cough | O YES | O NO | Neurological disorders | O YES | O NO |
| Other | O YES | O NO | If YES: | | |
| Cancer | | | Osteoporosis | O YES | O NO |
| Chemotherapy | O YES | O NO | Persistent swollen glands in neck | O YES | O NO |
| Radiation treatment | O YES | O NO | Recurrent infections | O YES | O NO |
| Type | O YES | O NO | Rheumatic fever | O YES | O NO |
| Cardiovascular disease | | | Severe headaches/ migraines | O YES | O NO |
| Angina | O YES | O NO | Severe or rapid weight loss | O YES | O NO |
| Chest pain upon exertion | O YES | O NO | Sexually transmitted disease | O YES | O NO |
| Congestive heart failure | O YES | O NO | Shingles | O YES | O NO |
| Damaged heart valves | O YES | O NO | Sinus trouble | O YES | O NO |
| Heart attack | O YES | O NO | Sleep disorder | O YES | O NO |
| Heart murmur | O YES | O NO | Stroke | O YES | O NO |
| High Cholesterol | O YES | O NO | Thyroid problems | O YES | O NO |
| High Blood Pressure | O YES | O NO | Tobacco | O YES | O NO |
| Low Blood Pressure | O YES | O NO | Interested in quitting? | O YES | O NO |
| Mitral valve prolapsed | O YES | O NO | Tuberculosis | O YES | O NO |
| Other congenital heart defects | O YES | O NO | Women Only | O YES | O NO |
| Pacemaker | O YES | O NO | Nursing | O YES | O NO |
| Rheumatic heart disease | O YES | O NO | Oral Contraceptives | O YES | O NO |
| Controlled Substances (Drugs) | O YES | O NO | Pregnant | O YES | O NO |
| If YES: | O YES | O NO | Due Date: | O YES | O NO |

If you have been hospitalized, had a serious illness, or operation within the past five years? If so, please explain below:

Do you have any other diseases, conditions, or problems that you feel we should know about? If so, please explain below:

To the best of my knowledge, the questions on this form have been answered accurately. I understand the importance of providing accurate health information to my dentist, as the dentist and staff will rely on this information for treating me, and I realize that incorrect or incomplete health information can be dangerous to my health.

SIGNATURE DATE