Excellence In Dentistry

Health History

Patient's Name: _____ Date of Birth: _____

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. **Indicate which of the following you have had, or currently have.**

Heart (Surgery, Disease, Attack) ____	Diabetes ____	Hepatitis A B C (circle) ____
Chest Pain ____	Thyroid Problems ____	A.I.D.S./H.I.V. Positive ____
Congenital Heart Disease ____	Glaucoma ____	Cold Sores/Fever Blisters ____
Heart Murmur ____	Emphysema ____	Blood Transfusion ____
High/Low Blood Pressure ____	Chronic Cough ____	Hemophilia ____
Mitral Valve Prolapse ____	Tuberculosis ____	Sickle Cell Disease ____
Artificial Heart Valve/Pacemaker ____	Asthma ____	Anemia/Bruise Easily ____
Rheumatic Fever ____	Sinus Trouble ____	Liver Disease/Jaundice ____
Arthritis ____	Radiation Therapy ____	Neurological Disorders ____
Stroke ____	Chemotherapy ____	Epilepsy or Seizures ____
Artificial Joints (hip, knee, etc.) ____	Cancer ____	Fainting or Dizzy Spells ____
Kidney Trouble ____	Tumors ____	Nervous/Anxious ____
Ulcers ____	Osteoporosis/Osteopenia ____	Psychiatric/Psychological Care ____

8. **Indicate which of the following you are currently using.**

Antibiotics ____	Bisphosphonates (Fosamax, Actenol, Aredia, Zomeda, Boniva, Forteo) ____
Blood Thinners ____	Tranquilizers ____
Aspirin/Ibuprofen ____	Insulin or Oral Anti-Diabetic drugs ____
High Blood Pressure medications ____	Digitalis, Inderal, Nitroglycerin or other heart drugs ____
Steroids (Cortisone, etc.) ____	

   Please list any and all medications taken, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals: _____

   _____

9. **Indicate which you are allergic to or have had an adverse reaction to.**

Local Anesthesia (Novocain, etc.) ____	Codeine ____
Penicillin ____	Latex or Rubber Products ____
Sedatives, Barbiturates ____	Other allergies or reactions? Please list _____
Aspirin or Ibuprofen ____	_____

10. Do you smoke or chew Tobacco? Yes No 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. **WOMEN:** Are you pregnant or think you could be pregnant? Yes No Are you nursing? Yes No
16. Do you use birth control prescriptions? ..... Y N

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. I have had the opportunity to discuss my Health History with my doctor. I will notify the doctor of any change in my health or medication.

_____ _____ _____

Date Signature of Person Completing Health History Doctor's Initials