HEALTH HISTORY

Mr. Mrs. Ms. Dr. ________________________________ Home Phone # (____)__________________
ADDRESS____ BUSINESS #(____)__________________
CITY_____________________STATE__________ZIP_____________Date of Birth_____/_____/____
Occupation____Social Security#______________________
Business Name and Address____
Emergency Contact Name_________________________________Phone # (____)__________________
Who referred you to our office____

DENTAL INFORMATION For the following questions, please place an (X) where it applies.

Yes No Don't know
___ ___ ___Are you having discomfort? Explain____
___ ___ ___Has a physician ever recommended that you take antibiotics prior to dental treatment?
___ ___ ___Do you currently take antibiotics prior to dental treatment?
___ ___ ___Have you had a serious/difficult problem associated with dental treatment? If so, please explain____

MEDICAL INFORMATION

Yes No Don't know
___ ___ ___Do you feel well (healthy) today?
___ ___ ___Are you in good health?
___ ___ ___Has there been any change in your general health within the past year?
___ ___ Do you smoke? How many years have you smoked________________________________
How much do you smoke daily____

Do you have any of the following diseases or problems?
___ ___ ___Active Tuberculosis
___ ___ ___Persistant cough
___ ___ ___Are you under the care of a physician? If so, what is/are the condition(s) being treated?
(i.e. Heart/Blood pressure)____
Physicians Name/Address_____________________________________Phone #(_____)______________

Yes No Don't know
___ ___ ___Any fever, malaise or change in weight in the last 2 weeks?
___ ___ ___Have you had any serious illness, operation or been hospitalized in the past 5 years?
___ ___ ___Are you alcohol and /or drug dependent?
___ ___ ___Do you use drugs or other substances for recreational purposes?
___ ___ ___Are you taking or have you recently taken any medicine(s) including non-prescription medicine (over the counter)? If so, what medicine(s) and dosage are you taking?
List all medications and dosages____
____
____

Allergies: Are you allergic to or have you had a reaction to:

Yes No Don't know
___ ___ ___Local anesthetics
___ ___ ___Aspirin
___ ___ ___Penicillin
___ ___ ___Codeine or other narcotics
___ ___ ___Other (Specify)____

Yes No Don't Know
___ ___ ___Latex, BandAids, Rubber
___ ___ ___Barbiturates, Sedatives
___ ___ ___Sulfa drugs
___ ___ ___Food

If yes response to any allergy, specify type of reaction____

(Women Only)

Yes No Don't know
___ ___ ___Are you pregnant?
___ ___ ___Taking birth control pills? (Antibiotics may inactivate birth control pills.)
___ ___ ___Nursing?

PLEASE TURN OVER AND COMPLETE QUESTIONS ON OTHER SIDE

Thank you

Please check YES or NO to the following diseases or problems.

Yes	No	Don't know		Yes	No	Don't know	
___	___	___	Abnormal bleeding	___	___	___	Heart Attack
___	___	___	Aids or HIV infection	___	___	___	Heart murmur
___	___	___	Anemia	___	___	___	Hepatitis, Jaundice, or Liver disease
___	___	___	Angina	___	___	___	High Blood Pressure
___	___	___	Arthritis	___	___	___	High Cholesterol
___	___	___	Artificial heart valves	___	___	___	Hip replacement
___	___	___	Asthma	___	___	___	Kidney problems
___	___	___	Cancer/chemotherapy/radiation	___	___	___	Knee replacement
___	___	___	Chest pains upon exertion	___	___	___	Mental health disorders
___	___	___	Chronic pain	___	___	___	Mitral valve prolapse
___	___	___	Claustrophobic	___	___	___	Pacemaker
___	___	___	Diabetes	___	___	___	Persistent diarrhea
___	___	___	Disease, drug or radioinduced immunosuppression	___	___	___	Recurrent infections
				___	___	___	Respiratory problems
___	___	___	Epilepsy	___	___	___	Rheumatic heart disease
___	___	___	Esophageal reflux	___	___	___	Sinus Trouble
___	___	___	Excessive urination	___	___	___	Stroke
___	___	___	Fainting spells or seizures	___	___	___	Thyroid problems
___	___	___	Glaucoma	___	___	___	Ulcer, heartburn

___ ___ ___Do you have any disease, condition or problem not listed above that you think I should know about? If so, please explain:____

____

____

Note: Both the doctor and patient are encouraged to discuss any other relevant patient issues prior to treatment. I consent to have-necessary examination; x-rays; periodontal or implant related surgery; local anesthesia. I acknowledge that I am responsible (for fees) for services rendered. I understand that if there are any post-operative problems or misunderstandings it is my obligation to return. I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.

______________________________________ ______________________

Signature of Patient/Legal Guardian Date

Below for completion by Dentist

Comments on patient interview concerning health history:

Significant Findings:

Dental management considerations:

______________________________________ ______________________

Signature of Dentist Date

Health History Update: On a regular basis the patient should be questioned about any medical history changes, dates and comments, along with signature.

__________ ____________________________ _________________________

Date Comments Signature of patient and dentist