HEALTH HISTORY FORM

Name: _____ Date: _____ Age: _____

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. Are you now under a physican's care for a particular problem? ..... Y N
4. Have you **ever** had any serious illnesses, operations or hospitalizations? If so describe: ..... Y N

   _____

   _____

   _____
5. Height _____ Weight _____

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, Mitral Valve Prolapse, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? ..... Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, 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? ..... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? ..... Y N
   - H. Kidney Disease? ..... Y N
   - I. Diabetes? ..... Y N
   - J. Thyroid Disease? ..... Y N
   - K. Arthritis? ..... Y N
   - L. Stomach Ulcers or Colitis? ..... Y N
   - M. Glaucoma? ..... Y N
   - N. Artificial heart valve; hip, knee or other replacement? ..... Y N
   - O. Radiation (X-ray) treatment for cancer? ..... Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth? ..... Y N
   - Q. Sinus or Nasal problems? ..... Y N
   - R. 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 (Prednisone)? ..... Y N
   - F. Insulin or Oral Anti-Diabetic drugs? ..... Y N
   - G. Digitalis, Nitroglycerin or other heart drug? ..... Y N
   - H. Are you taking or have you ever taken Bisphosphanates (Fosamax, Actonel or Boniva for osteoporosis or Aredia or Zometa for cancer)? ..... Y N
   - I. Have you ever taken Redux or Fen-Phen? ..... Y N
   - J. Please list any and all medications currently taking, including prescription medications, 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 (Lidocaine, etc.)? ..... Y N
   - B. Penicillin or other antibiotics? ..... Y N
   - C. Sedatives? ..... Y N
   - D. Aspirin or Ibuprofen? ..... Y N
   - E. Codeine or other pain killers? ..... Y N
   - F. Latex or Rubber Products? ..... Y N
   - G. Other allergies or reactions? Please list ..... Y N

     _____

     _____
9. Do you smoke or chew Tobacco? ..... Y N
   How much per day? _____ For how long? _____
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 previous dental treatment? ..... Y N
12. Have you or an immediate family member had any problem associated with 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. **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.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have read and understand the above.

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

For Completion by Doctor: (Comments regarding medical history):

_____

_____

_____

Medical History Update

Date _____ Comments _____ Doctor's Initals _____