HEALTH HISTORY

NAME: ____ Date of Birth:______________________________

GENERAL HEALTH: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR Date of last dental cleaning:___________________

ALL PATIENTS: Do you have, or have you ever had any of the following? **(CHECK ALL THAT APPLY)**

☐ NONE

- ☐ ACID REFLUX
- ☐ ADHD
- ☐ AIDS OR HIV INFECTION
- ☐ ANEMIA
- ☐ ANOREXIA / BULIMIA
- ☐ ANXIETY
- ☐ ARTHRITIS
- ☐ ARTIFICIAL HEART VALVE
- ☐ ARTIFICIAL JOINTS
- ☐ ASTHMA
- ☐ AUTISM / ASPERGER'S
- ☐ BLOOD / BLEEDING DISORDER
- ☐ CANCER _________________
- ☐ CHEMOTHERAPY / RADIATION
- ☐ DEPRESSION
- ☐ DIABETES – type____________
- ☐ DIZZINESS / FAINTING
- ☐ EPILEPSY / SEIZURES
- ☐ FREQUENT EAR INFECTIONS
- ☐ FREQUENT HEADACHES
- ☐ HEARING PROBLEMS
- ☐ HEART ATTACK
- ☐ HEART DISEASE
- ☐ HEART MURMUR
- ☐ HEPATITIS – type___________
- ☐ HIGH BLOOD PRESSURE
- ☐ IMMUNE SYSTEM DISORDERS
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ PACEMAKER
- ☐ PSYCHIATRIC TREATMENT
- ☐ RESPIRATORY DISEASE
- ☐ RHEUMATIC FEVER
- ☐ SINUS PROBLEMS
- ☐ STOMACH PROBLEMS
- ☐ STROKE
- ☐ SUBSTANCE or ALCOHOL ABUSE
- ☐ THYROID CONDITION
- ☐ TOBACCO USE / VAPING _________
- ☐ TUBERCULOSIS
- ☐ ULCERS
- ☐ VENEREAL DISEASE / STD
- ☐ OTHER – PLEASE LIST

ALLERGIES ☐ NONE

- ☐ ACETAMINOPHEN
- ☐ ANESTHETIC - LOCAL
- ☐ ASPIRIN
- ☐ BENZODIAZEPINES
- ☐ CODEINE
- ☐ IBUPROFEN
- ☐ LATEX
- ☐ SULFA DRUGS
- ☐ PENICILLIN
- ☐ OTHER (PLEASE LIST)

MEDICATIONS (list) ☐ NONE

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☐ Y ☐ N Are you currently under a physician's care? If yes, specify condition being treated ______________________________

☐ Y ☐ N Have you been hospitalized in the past 5 years? ____

☐ Y ☐ N Do you have any other health problems that need further clarification or that we need to be aware of? ______________

☐ Y ☐ N Do you require antibiotic pre-medication prior to dental treatment? Please specify reason: Artificial joint____________ Artificial Heart Valve____; Infective endocarditis____; Congenital heart disease____; Other:______________________

☐ Y ☐ N Are you taking or have you taken Bisphosphonates (orally or IV) including Fosamax, Boniva, zolendronate, or any other drugs prescribed to decrease the resorption of bone as in osteoporosis or for metastatic bone cancer?

☐ Y ☐ N Have you ever had radiation treatment to the head or neck?

☐ Y ☐ N Are you taking any blood thinners (Coumadin, Warfarin, Xarelto, Pradaxa, Plavix, heparin, aspirin, or other)?

☐ Y ☐ N Have you ever had any complications during or after dental treatment? ____

FEMALE PATIENTS: ☐ Y ☐ N Currently nursing? ☐ Y ☐ N Currently pregnant? Due Date _______________

I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY ABILITY. SINCE A CHANGE IN MY MEDICAL CONDITION OR IN MEDICATIONS I TAKE CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO TAKE THE RESPONSIBILITY TO NOTIFY THE DENTIST OF ANY CHANGES TO ANY SUBSEQUENT APPOINTMENT

Signature_____________________________________ **Date**_________________________

(Patient, legal guardian, or authorized agent of patient)

Patient Signature	Date	Exceptions	Reviewed By