HEALTH HISTORY

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Patient's Name | Date of Birth | Age | Height | Weight | Date

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

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6. **DO YOU HAVE OR HAVE YOU EVER HAD**:
   - A. Hypertension/High Blood Pressure?............ Y N
   - B. Congenital Heart Disease?............ Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, Chest Pain, Stroke, Heart Surgery, Pacemaker)?............ Y N
   - D. Arrhythmia, Irregular Heart Beat, Palpitations?............ Y N
   - E. Heart Valve or Heart Murmur problems, Rheumatic Heart Disease?............ Y N
   - F. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Obstructive Sleep Apnea, Severe Coughing)?............ Y N
   - G. Seizures, Convulsions, Epilepsy, Fainting or Dizziness?............ Y N
   - H. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily?............ Y N
   - I. Liver Disease (Jaundice, Hepatitis)?............ Y N
   - J. Kidney Disease?............ Y N
   - K. Diabetes?............ Y N
   - L. Thyroid Disease (Goiter)?............ Y N
   - M. Arthritis?............ Y N
   - N. Stomach Ulcers, Colitis, Gastroesophageal Reflux?............ Y N
   - O. Glaucoma?............ Y N
   - P. Osteoporosis?............ Y N
   - Q. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)?............ Y N
   - R. Radiation (X-ray) treatment for Cancer?............ Y N
   - S. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth............ Y N
   - T. Sinus or Nasal problems?............ Y N
   - U. Any disease (i.e. HIV/AIDS), 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 (Cortisone, Prednisone, etc.)?............ Y N
   - F. Tranquilizers?............ Y N
   - G. Insulin or Oral Anti-Diabetic drugs?............ Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug?............ Y N
   - I. Are you taking or ***have you ever taken*** Bisphosphonates or RANK Ligand Inhibitor for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia)?............ Y N
   - J. Have you ever been advised ***not*** to take a medication?............ Y N
   - K. Please list any and all medications taken, including prescriptions, diet drugs, over the counter medications, recreational drugs, herbal or holistic, vitamins or minerals:

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8. **HAVE YOU HAD AN ALLERGIC REACTION TO OR ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocaine, etc.)?............ Y N
   - B. Penicillin or other antibiotics?............ Y N
   - C. Sedatives, Barbiturates?............ Y N
   - D. Aspirin or Ibuprofen?............ Y N
   - E. Codeine or other pain killers?............ Y N
   - F. Latex or Rubber products?............ Y N
   - G. Metal of any kind?............ Y N
   - H. Chemicals or jewelry (rash or sensitivity)?............ Y N
   - I. Food products (egg, soy, etc)............ Y N
   - J. Please list all **DRUG** and other allergies or reactions: ___________

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9. Do you smoke?............ Y N
   How much per day? ____________
10. Do you use smokeless tobacco (chew/snuff)?............ Y N
11. Is there any past history of Alcohol or Chemical Dependency, Emotional or Eating Disorder............ 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. Do you wish to talk to the doctor privately about anything?............ Y N
16. Have you ever had a bone density scan?............ Y N
17. **FOR WOMEN ONLY**
   - A. Are you Pregnant, or is ***there a 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. Please consult with your physician for further guidance.

I understand the importance of a truthful and complete Health History to assist my dentist in providing the best care possible. I have had the opportunity to discuss my Health History with my dentist.

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