HEALTH HISTORY

Patient's Name: _____

Primary Care Physician: _____ Month / Year of last visit: _____

Address: _____ Phone: _____

Have you ever been told you need to PREMEDICATE or TAKE ANTIBIOTICS prior to a dental procedure? ❑Y ❑N

Reason for Premedication: _____

FOR OFFICE USE ONLY: Continue to Premed (per physician & based on April '07 AHA guidelines)? ❑Y ❑N

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

CARDIOVASCULAR

Angina (Chest Pain)	❑Y ❑N
Arteriosclerosis	❑Y ❑N
Atrial Fibrillation	❑Y ❑N
Circulation Problems	❑Y ❑N
Heart Attack (Year _____)	❑Y ❑N
Heart Defect	❑Y ❑N
Heart Murmur / Leaky Valve	❑Y ❑N
Heart Valve Replacement	❑Y ❑N
High or Low Blood Pressure	❑Y ❑N
MVP (Mitral Valve Prolapse)	❑Y ❑N
Pacemaker / Defibrillator	❑Y ❑N
Scarlet Fever	❑Y ❑N
Stroke (Year_____)	❑Y ❑N
Swelling of Feet or Ankles	❑Y ❑N

CIRCULATORY

Abnormal Bleeding	❑Y ❑N
Anemia	❑Y ❑N
Blood Disease	❑Y ❑N
Leukemia / Lymphoma	❑Y ❑N

INFECTIOUS DISEASES

Herpes (Type_____)	❑Y ❑N
HIV / AIDS	❑Y ❑N
Swollen Glands – Neck	❑Y ❑N
Tuberculosis	❑Y ❑N

NEUROLOGICAL

Dizziness / Fainting	❑Y ❑N
Epilepsy / Seizures	❑Y ❑N
Headaches	❑Y ❑N
Hearing Impairment	❑Y ❑N
Vision Impairment	❑Y ❑N

RESPIRATORY

Asthma	❑Y ❑N
Cough – Bloody or Persistent	❑Y ❑N
Emphysema	❑Y ❑N
Psychiatric Care	❑Y ❑N
Shortness of Breath	❑Y ❑N
Sinus / Nasal Problems	❑Y ❑N

GASTROINTESTINAL

Diarrhea - Persistent	❑Y ❑N
Digestive Disorder / Colitis	❑Y ❑N
Hepatitis (Type _____)	❑Y ❑N
Hiatal Hernia	❑Y ❑N
Liver Disease / Jaundice	❑Y ❑N
Ulcer / Hyperacidity	❑Y ❑N

ENDOCRINOLOGICAL

Diabetes (Type _____)	❑Y ❑N
Thyroid _____	❑Y ❑N

MUSCULOSKELETAL

Arthritis / Rheumatism	❑Y ❑N
Cortisone / Steroid Treatment	❑Y ❑N
Joint Replacement (_____)	❑Y ❑N
Osteoporosis	❑Y ❑N

OTHER

Autoimmune / Lupus	❑Y ❑N
Immune Problems	❑Y ❑N
Cancer (Type_____)	❑Y ❑N
Glaucoma	❑Y ❑N
Kidney Disease	❑Y ❑N
Unexplained Weight Loss	❑Y ❑N

FOR WOMEN ONLY

Are you pregnant?	❑Y ❑N
Could you be pregnant?	❑Y ❑N
Are you breastfeeding?	❑Y ❑N
Are you on birth control pills?	❑Y ❑N

SURGERIES

Please list ALL past surgeries (major and minor) _____

_____

_____

_____

Please list any other medical concerns/conditions that your dentist should know about. _____

_____

MEDICATIONS

Please list all medications and vitamins you are taking.

_____

_____

_____

_____

_____

Are you taking or have you ever taken Bisphosphonates (Fosamax or Actonel for osteoporosis or chemo therapy for multiple myeloma, etc.)? ❑Y ❑N

TOBACCO USE

(Circle all that apply.)

Cigarettes Cigars Pipe Chew/Dip

How often? _____

ALLERGIES

Aspirin or Ibuprofen	❑Y ❑N
Codeine	❑Y ❑N
Other Pain Killers _____	❑Y ❑N
_____	
Iodine	❑Y ❑N
Latex / Rubber Products	❑Y ❑N
Local Anesthesia (Lidocaine, Epinephrine, etc)	❑Y ❑N
Penicillin	❑Y ❑N
Other Antibiotics _____	❑Y ❑N
Sulfa	❑Y ❑N

Please list other allergies or sensitivities.

_____

_____

DENTAL INQUIRIES

Teeth Sensitivity	❑Y ❑N
Bleeding Gums	❑Y ❑N
Food Impaction	❑Y ❑N
Frequent blisters (lips/mouth)	❑Y ❑N
Mouth Breathing	❑Y ❑N
Oral habits (i.e. nail biting, cheek biting, etc.)	❑Y ❑N
Clenching / Grinding	❑Y ❑N
Pain Around Ear	❑Y ❑N
Clicking or popping of jaw joint	❑Y ❑N
Unusual sounds in ear while eating	❑Y ❑N
Periodontal treatment	❑Y ❑N
Orthodontic treatment	❑Y ❑N
Unfavorable dental experience	❑Y ❑N
Dry mouth syndrome	❑Y ❑N

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the above inquiries have been answered to my satisfaction. I will not hold my dentist, or members of his staff, responsible for any errors or omissions that I may have made in the completion of this form. If I ever have any changes to my health, I will inform my dentist at my next appointment without fail.

_____ _____

Signature of Patient – Parent or Guardian (if under 18) Date