Patient's Name

/

Birth Date / Today's Date

HEALTH HISTORY FORM – Part I

If you are completing this form for another person, what is your relationship to that person?

Your Name ______________________ Relationship ______________________

Allergies – Are you allergic to or have you had a reaction to any of the following? (If yes, please specify. Check DK for Don't Know)

	No	Yes	DK		No	Yes	DK
Local Anesthetics ____	☐	☐	☐	Metals/Nickel ____	☐	☐	☐
Aspirin ____	☐	☐	☐	Latex (rubber) ____	☐	☐	☐
Penicillin/Other Antibiotics ____	☐	☐	☐	Hay Fever/Seasonal ____	☐	☐	☐
Barbiturates/Sleeping Pills ____	☐	☐	☐	Codeine/Other Narcotics ____	☐	☐	☐
Other (Explain) ____	☐	☐	☐				

Do you have any of the following diseases or problems?

	No	Yes	DK		No	Yes	DK
Active Tuberculosis	☐	☐	☐	Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐	Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Medical Information

Are you now under the care of a physician? ☐ ☐ ☐

Physician's Name ______________________

Physician's Address ______________________

Are you in good health? ☐ ☐ ☐

Has there been any change in your general health within the past year? ☐ ☐ ☐

If yes, what condition is being treated? ______________________

____

____

Date of last physical exam: ______________________

Have you had a serious illness, operation or been hospitalized in the past 5 years? ☐ ☐ ☐

If yes, why? ______________________

____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? ☐ ☐ ☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: ______________________

____

Bone Health/Joint Replacement

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Date: ____________ ☐ ☐ ☐

Are you scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? ☐ ☐ ☐

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from osteoporosis, Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐ ☐

Date treatment began: ____________

HEALTH HISTORY FORM – Part II

Patient Name ______________________ Birth Date / Today's Date ______ / ______

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems. (Check DK if you Don't Know the answer.)

	No	Yes	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
**Unrepaired, cyanotic CHD*	☐	☐	☐
**Repaired (completely) in past 6 mos.*	☐	☐	☐
** Repaired CHD with residual defects*	☐	☐	☐
Heart attack (when?) ________	☐	☐	☐
High blood pressure	☐	☐	☐
Blood thinner usage	☐	☐	☐
Pacemaker/ICD	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date ________			
Hemophilia	☐	☐	☐
AIDS or HIV infections	☐	☐	☐
Arthritis (type)	☐	☐	☐
Dry mouth	☐	☐	☐
Mouth ulcers	☐	☐	☐

	No	Yes	DK
Autoimmune disease	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Cancer/Chemo/Radiation Tx	☐	☐	☐
Where on body? ________			
Tumors	☐	☐	☐
Low blood pressure	☐	☐	☐
Dizziness	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G. E. Reflux/heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Stroke	☐	☐	☐
TMJ disorder	☐	☐	☐

	No	Yes	DK
Hepatitis/jaundice/liverdisease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells/seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: ________			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: ________	☐	☐	☐
Recurrent infections	☐	☐	☐
Type of infection: ________			
Kidney problems	☐	☐	☐
Night Sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands (neck)	☐	☐	☐
Severe headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Thyroid problems	☐	☐	☐
Glaucoma	☐	☐	☐
Head injuries	☐	☐	☐

**Except for the conditions noted above, antibiotic prophylaxis is no longer recommended for any other form of CHD*.

	No	Yes	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you drink alcoholic beverages?	☐	☐	☐

	No	Yes	DK
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐

If so, how interested are you in stopping? VERY / SOMEWHAT / NOT INTERESTED

If yes, how much alcohol did you drink in the last 24 hours? ________

If yes, how much do you typically drink in a week? ________

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation: ________ Phone: ________

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐

Please explain: ________

Note: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

________ Signature of Patient/Legal Guardian ________ Printed Name ________ Date

FOR COMPLETION BY DENTIST

Comments: ________