Health History

Date of Last Health Care exam and reason for exam

Please list all the names and phone numbers of the physicians who are currently providing you care

Have you been hospitalized within the last five years?

Are you currently receiving care? If yes, nature of care

Do you have any of the following

- ◯ Anemia or Blood Disorder
- ◯ Asthma
- ◯ Cancer or tumor
- ◯ Emphysema or other respiratory Illnesses
- ◯ Glaucoma
- ◯ Abnormal heart or bacterial endocarditis
- ◯ Congenital Heart Disease
- ◯ Heart Murmur
- ◯ Hepatitis (Any form)
- ◯ Sore/Enlarged Lymph Nodes
- ◯ Radiation or Chemotherapy Treatment
- ◯ Arthritis, Rheumatism or other inflammatory disease
- ◯ Abnormal bleeding from a cut
- ◯ Diabetes (Type I or Type II)
- ◯ Fainting of dizzy spells
- ◯ Epilepsy
- ◯ Artificial Heart Valve or Heart Transplant
- ◯ Heart Disease, Heart Attack or Heart Surgery
- ◯ Heart Stent? When placed?
- ◯ Liver Disease (Including Jaundice)
- ◯ Psychosis
- ◯ Rheumatic Fever

- ◯ Slow healing mouth sores
- ◯ HIV/AIDS or ARC
- ◯ Venereal Disease
- ◯ Recurrent Illness
- ◯ High Cholesterol
- ◯ Unintentional weight gain / loss
- ◯ Thyroid Disease
- ◯ Other conditions
- ◯ High Blood Pressure

Medication List – please include prescription drugs, dosages, as well as dietary or herbal supplements

Are you currently taking or have you taken in the past any of the following medications?

- ◯ PreMedication before dental treatment
- ◯ Dilantin or tegretol
- ◯ St. Johns wart of kava-kave
- ◯ Cardizem (Diltiazem) or Calan, Isoptin
- ◯ Antacids
- ◯ Barbituates (any)
- ◯ Tagamet (cimetidine or Prilosec (omeprazole)
- ◯ Serzone (nefazodone)
- ◯ Diflucan (fluconazole) or Sporonox (itraconazole)
- ◯ Biaxin (clarithromycin)
- ◯ Bisphosphonate drugs (Fosamax, aredia, zometa, Actonel, Boniva)
- ◯ Prescription drugs for weight loss such as phen-phen
- ◯ Grapefruit juice, grapefruits or grapefruit extract

Women

Are you pregnant? ◯ Yes ◯ No

If no, are you planning a pregnancy in the near future? ◯ Yes ◯ No

Are you a nursing mother? ◯ Yes ◯ No

Are you taking birth control? ◯ Yes ◯ No

Are you allergic or have you had a reaction to

- ◯ Local Anesthetics
- ◯ Aspirin, ibuprofen or Tylenol

◯ Latex or metal ◯ Penicillin or other antibiotics

◯ Codeine, valium or other sedatives ◯ Any other allergies

Tobacco, Alcohol, Drugs

Do you use tobacco? Smoke or chew? How much per day? ◯ Yes ◯ No

Do you want to quit using tobacco? ◯ Yes ◯ No

Do you consume alcohol? If yes, approx. how many beverages per week? ◯ Yes ◯ No

Do you use any mood altering drugs other than those previously listed?

Weight and Diet Considerations

Weight	Meals per day	Dietary Restrictions	Food Allergies

Sugar in your diet (Cirlce one): None Slight Moderate High

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

Patient (Print Name) *Patient Signature* *Date*

Doctor (Print Name) *Doctor Signature* *Date*