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Health History

Name: _____ Date: _____

Date of last health care exam: _____ What was this exam for: _____

Have you been hospitalized in the last 5 years? (please circle) No Yes

If yes, reason: _____

Are you currently receiving medical care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the dentists and physicians who are providing care for you:

1. General Dentist: _____
2. Primary Care MD: _____
3. Specialist MD: _____
4. Pharmacy: _____

For the following questions, please circle yes or no, and what conditions/meds apply to you. Your answers are for our records only and will be confidential. Please note that our team may ask additional questions concerning your health in order to optimize your care.

Anemia or Blood Disorder	No	Yes	Hepatitis, Type: _____	No	Yes
Diabetes—Type I or Type II Last HbA1C: Blood Glucose:	No	Yes	Liver disease, Jaundice	No	Yes
Asthma, COPD, Emphysema, Shortness of Breath Been hospitalized for condition?	No No	Yes Yes	Joint replacement what joint_____ When placed?	No	Yes
Sleep Apnea	No	Yes	HIV / AIDS CD4/CD8 count_____	No	Yes
Abnormal bleeding or bruise easily	No	Yes	Kidney disease Stage_____	No	Yes
Epilepsy, Seizure, fainting spells	No	Yes	Psychiatric Care	No	Yes
Abnormal Heart Beat	No	Yes	Stroke	No	Yes
Heart disease, Heart attack, and/or Heart surgery	No	Yes	Cancer or tumor Radiation or Chemotherapy Date:_____	No	Yes
Heart stent when placed?	No	Yes	Glaucoma	No	Yes
Heart murmur, heart valve disease	No	Yes	Rheumatic or Scarlett Fever	No	Yes
Heart and/or valve replacement	No	Yes	Recurrent sinus infections	No	Yes
Previous Bacterial Endocarditis	No	Yes	Mouth sores	No	Yes
Autoimmune Disease (Arthritis, Lupus, Sjogren's)	No	Yes	Other conditions	No	Yes
Thyroid, parathyroid or calcium deficiency	No	Yes	Hormone deficiency or Hormone Replacement Therapy	No	Yes
Digestive Disorder (Gastric reflux, Celiac, Crohn's UC)	No	Yes	STI/STD	No	Yes

High or Low Blood Pressure (please circle) What is your normal blood pressure: _____

Family History of Autoimmune Disorders (Lupus, RA, etc.), genetic disorders, mouth sores:_____

Medications/Reason for use:

Please list any medications (prescription and over-the-counter) you are currently taking, include any medication patches and meds for smoking cessation:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Please list any dietary or herbal supplements you are taking and for what purpose:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

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Are you taking any of these medications?

Pre-medication prior to dental treatment?	No	Yes	Cardizem (Diltiazem), Verapamil, Amlodipine, Nifedipine	No	Yes
Antacids (Prilosec, Tagamet, Zantac)?	No	Yes	SSRIs (Zoloft, Paxil, Prozac, Celexa, Lexapro)	No	Yes
Dilantin, Tegretol or other anti-seizure medication	No	Yes	Diflucan (fluconazole) or other Antifungals	No	Yes
Barbiturates	No	Yes	Antibiotics	No	Yes
St. John's Wort, Kava-Kava, Grapefruit	No	Yes	Immunosuppressants (Humira, Remacade, Enbrel)?	No	Yes
Fish, Krill, or Flax Oil; Vitamin E	No	Yes	NSAIDS (ibuprofen, Meloxicam)		
Have you ever been treated for **Osteoporosis or Cancer** with **Bisphosphonate** drugs (Fosomax, Aredia, Zometa, Actonel, Boniva, Reclast, Xgeva, Prolia, Denosudum, Didrolel, Aclast, Atelvia, Skelid)? If so when did treatment begin? End?				No	Yes
Anticoagulants: (Aspirin, Coumadin/Warfarin, Plavix/Clopidogrel, Xarelto/Rivaroxaban, Eliquis/Apixaban, Enoxaparin/Lovenox, Pradaxa/Dabigatran, Savaysa/Edoxaban, Arixtra/Fondaparinux, Brilinta/Ticagrelor)?				No	Yes

Allergies/Adverse Reactions

Are you allergic or have you had a reaction to:			Type of Reaction
a. Latex or Metals	No	Yes	_____
b. Antibiotics	No	Yes	_____
(please circle) Penicillin; Sulfa; Erythromycin; Tetracycline, other			_____
c. Aspirin, Ibuprofen, Tylenol	No	Yes	_____
d. Local anesthetics, including topical	No	Yes	_____
e. Codeine, Valium, or other sedatives	No	Yes	_____
f. Sulfites or preservatives	No	Yes	_____
g. Other	No	Yes	_____

Women:

a. Are you pregnant?	No	Yes
b. Are you a nursing mother?	No	Yes

Tobacco, Alcohol, Drugs

Do you use nicotine? If yes, circle type: cigarette E-cig Vape Chew How much per day? For how many years?	No	Yes
Do you want to quit using nicotine/tobacco?	No	Yes
Have you ever used nicotine/tobacco in the past? How much? For how long? How long since you've quit?	No	Yes
Do you consume alcohol? If yes, approximately how many drinks per week?	No	Yes
Do you use any mood altering drugs other than those listed previously?	No	Yes

Is there anything else we should know about your health that was not covered by this questionnaire?

_____

_____

Patient (Print Name) _____ Patient Signature_____ Date_____

Doctor (Print Name) _____ Doctor Signature_____ Date_____

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