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 care? No Yes If yes, nature of care: _____

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

1. _____
2. _____
3. _____
4. _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Heart Murmur (mitral valve prolapse)	No	Yes	Psychosis	No	Yes
Anemia	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Slow-Healing Mouth Sores	No	Yes
Hepatitis, Any Form	No	Yes	Other Infections	No	Yes
Rheumatic Fever	No	Yes	Recurrent Illnesses	No	Yes
Asthma	No	Yes	Joint Replacement	No	Yes
HIV Positive or AIDS Related Complex	No	Yes	Glaucoma Narrow Angle or Wide Angle	No	Yes
Emphysema or other Respiratory Illnesses	No	Yes	Abnormal Bleeding from a cut	No	Yes
Abnormal Heart Condition	No	Yes	Liver Disease (including Jaundice)	No	Yes
Kidney Disease	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart (Surgery, Disease, Attack)	No	Yes	Latex Sensitivity	No	Yes
Venereal Disease	No	Yes	H.I.V. Infection/AIDS	No	Yes
Taken Phentermine or other diet pills	No	Yes	Do you get botox injections?	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Tagamet (Cimetidine)?	No	Yes
Antacids?	No	Yes	Herbal supplements?	No	Yes
Have you been treated with Bisphosphonate drugs?				No	Yes
Are you currently taking any prescription or non-prescription Anti-Fungal Medication?				No	Yes

Please list any medications you are currently taking:

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

Are you required to Pre-Medicate before dental treatment ? No Yes
(Due to heart problems, joint replacement, and rheumatic fever)

Do you have a sleep disorder? (Example: Restless Legs Syndrome, Night Terrors) No Yes

Women: Are you pregnant? No Yes
If no, are you planning a pregnancy in the near future? No Yes
Are you a nursing mother? No Yes
Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (Please circle) No Yes
If yes, what is it usually: S /D

Are you allergic or have you had a reaction to:

a. Local anesthetics ……... No Yes
b. Penicillin or other antibiotics …… No Yes
c. Aspirin ……..……... No Yes
d. Codeine, valium or other sedatives…….… No Yes
e. Other _____

Are you a smoker? No Yes

If so, how much do you smoke per day? _____

Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes

Weight: _____

Diet: Restricted Diet _____

How many meals a day _____

Food Allergies _____

Sugar in your diet: ❑ 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*