HEALTH HISTORY

Name_____**Date**_____

Date of last health care exam_____ **What was the exam for?**_____

Have you been hospitalized in the last 5 years? (Please Circle) Yes No

If yes, reason:_____

Are you currently receiving care: No Yes If yes, nature of care_____

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

1. _____
2. _____
3. _____

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	Stroke	No	Yes
Diabetes	No	Yes	Previous Biopsies/Cancer	No	Yes
Epilepsy	No	Yes	Abnormal Blood Pressure	No	Yes
Hepatitis (any form)	No	Yes	Sore/Enlarged Lymph Nodes	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	Sleep Apnea/Sleep Disorders	No	Yes
HIV Infection/AIDS	No	Yes	Abnormal Bleeding from a cut	No	Yes
Abnormal Heart Condition	No	Yes	Unintentional weight loss/gain	No	Yes
Kidney Disease	No	Yes	Latex sensitivity	No	Yes
Heart (surgery, disease, attack)	No	Yes	Slow-healing mouth sores	No	Yes
Venereal disease	No	Yes	Liver Disease-including Jaundic	No	Yes

Are you required to Pre-Medicate before dental treatment? No Yes

Women: Are you pregnant? No Yes
Are you a nursing mother? No Yes
Are you taking birth control pills? No Yes

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. Other_____ **No Yes**

Are you a smoker? No Yes If yes, how much do you smoke per day?_____
Do you consume grapefruit juice, grapefruits, or grapefruit extra No Yes

Please list any medications you are currently taking:

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

Are you taking Tagament? (Cimetidine)? No Yes If yes, how often?_____

Do you take Antacids? No Yes If yes, how often?_____

Are you taking any herbal supplements/medicines? No Yes If yes, which ones?_____
Diet: Restricted Diet_____
Food Allergies_____

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 healtl and medication.

_____	_____	_____
Patient (print name)	**Patient signature**	**Date**
_____	_____	_____
Doctor (print name)	**Doctor Signature**	**Date**

DOCTORS USE ONLY:

Comments on patient interview concerning medical history:
_____

Significant findings from questionnaire or oral interview:
_____

Dental management considerations:
_____

Information update:

Have you had a change in your health since your last visit No yes

Heart surgery, disease, or attack	**No Yes**	**Hepatitis, Any form**	**No Yes**
Heart murmur (mitral valve prolapse)	**No Yes**	**Rheumatic Fever**	**No Yes**
Joint Replacement	**No Yes**	**HIV or AIDS**	**No Yes**
Taken Fen-phen or other diet pills	**No Yes**		

Have you had a visit to a physician since your last dental visit? No Yes
Are you pregnant? No Yes Are you a nursing mother? No Yes
Please list any medications you are currently taking:
1._____ 2._____
3._____ 4._____

Do you have allergies? No Yes List:_____

Signature_____Date_____