 **Health History**

| Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physician’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| --- | --- |

**Please circle Yes (Y), No (N) for your responses(s) to indicate if you have or have not had any off the following diseases or problems**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Cardiovascular** | **Y** | **N** | **If yes, please specify** | **Neurologic** | **Y** | **N** | **If yes, please specify** |
| Blood thinner (please select type)1. Asprin (F) Pradaxa
2. Plavix (G) Effient
3. Eliquis (H) Brilinta
4. Xarelto (I) Savaysa
5. Coumadin/ (J) Other

 Warfarin | Y | N |  | Fainting spells | Y | N | When |
| High/Low Blood Pressure | Y | N | Circle one:  High Low | Stroke/CVA | Y | N | Type |
| Congestive heart failure | Y | N | When  | Neuralgia | Y | N |  |
| Rheumatic heart disease | Y | N | When | Shingles | Y | N |  |
| Angina or chest pain | Y | N | Type | Seizures/epilepsy | Y | N | Last time? |
| Heart surgery | Y | N  | When | Paralysis | Y | N |  |
| Coronary bypass surgery | Y | N | Date | Glaucoma | Y | N  |  |
| Stents | Y | N | Date | Hearing loss | Y | N |  |
| Myocardial infarction (heart attack) | Y | N | When | Severe headaches | Y | N |  |
| Pacemaker defibrillator | Y | N | When | **Gastrointestinal/Liver** | **Y** | **N** | **If yes, please specify** |
| Arrhythmias/Atrial fibrillation | Y | N |  | Stomach Ulcers | Y | N |  |
| Aneurysm | Y | N |  | Gastritis | Y | N |  |
| Shortness of breath | Y | N |  | GERD/Reflux | Y | N |  |
| Swollen ankles | Y | N |  | Hepatitis | Y | N | Type |
| Previous infective endocarditis | Y | N |  | Liver disease | Y | N | When |
| Damaged valves in transplanted heart | Y | N |  | Jaundice | Y | N |  |
| Congenital heart disease (CHD) | Y | N |  | Cirrhosis | Y | N |  |
| Unrepaired cyanotic (CHD) | Y | N |  | History of C. difficile | Y | N | When |
| Repaired (completely) in last 6 months | Y | N |  | Chron’s diseaseUlcerative Colitis  | YY | NN | WhenWhen |
| Repaired CHD with residual defects | Y | N |  |
| **Hematologic** | **Y** | **N** | **If yes, please specify** | **Respiratory** | **Y** | **N** | **If yes, please specify** |
| Blood transfusion | Y | N | When | Emphysema | Y | N | O2 Therapy? |
| Anemia | Y | N |  | Bronchitis | Y | N |  |
| Hemophilia | Y | N |  | Tuberculosis | Y | N |  |
| Leukemia | Y | N | When | Sleep disorders | Y | N |  |
| Sickle cell disease | Y | N | Type |
| Bleeding tendencies | Y | N |  |
| Clotting disorders | Y | N |  |
| **Immune System** | **Y** | **N** | **If yes, please specify** | (Musculoskeletal continued)Osteopenia or osteoporosis | Y | N |  |
| HIV positive | Y | N |  | Are you or have you taken an anti-resorptive agent for osteoporosis or Paget’s disease?.......................................... Yes NoIf yes, please select from the following: Oral Bisphosphonate(Actonel/Boniva/Fosamax/Atelvia) □ OrIV Bisphosphonate (Aredia/Zometa/Bonefos/Reclast/Prolia) □ |
| Sjogren’s syndrome | Y | N |  | **Endocrine** | **Y** | **N** | **If yes, please specify** |
| Genitourinary | Y | N | If yes, please specify | DiabetesA1C ≥ 6 in the past 12 months? | YY | NN |  |
| Kidney problems | Y | N | Kidney problems | Thyroid disease | Y | N |  |
| Taking or ever taken steroids? | Y | N | How long? |
| Other | Y | N |  |
| Dialysis | Y | N |  | **Pre-medication** |
| Sexually transmitted disease | Y | N |  | Have you had an orthopaedic total joint (hip, knee, elbow, shoulder replacement?....................................... Yes No  Date of implant:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Human papilloma virus (HPV) positive | Y | N |  |
| Other | Y | N | Specify | Have you had a joint replacement in the last 6 months?.............................................. Yes No  |
| **Musculoskeletal** | **Y** | **N** | **If yes, please specify** | Have you had a heart transplant?.......................... Yes NoDate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Arthritis | Y | N | Arthritis |  Have you had an artificial heart valve?................. Yes No |
| Bone disorder | Y | N | Bone disorder |  Have you been required to pre-medicate prior or after dental visits? ……………………… Yes No |
| Muscle disorder  | Y | N |  |  If so, which antibiotic is prescribed? |
| Rheumatoid Arthritis  | Y | N  | Iv infusions? | Any complications with joint replacement?........... Yes No |
| Immunosuppressant drugs | Y | N  |  | Orthopaedic surgeon’s name:Phone # |
| Systemic lupus erythematosus | Y | N |  |

|  |  |
| --- | --- |
|  **Yes No** 1. Are you in good health?.................................... Y N

If no or don’t know, please explain?Allergies: Are you allergic to or have you had a reaction to any of the following?  **To all yes response, specify types****of reaction.**Latex\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Y N Penicillin\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Y N Other antibiotics\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Y N General anesthetics\_\_\_\_\_\_\_\_\_\_\_\_ Y N Local anesthestics\_\_\_\_\_\_\_\_\_\_\_\_\_ Y N Aspirin\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Y N Codeine or other narcotics\_\_\_\_\_\_ Y N 1. Are you now under the care

of a physician?.................................................... Y N If yes, what is/are the conditions being treated?Physician or Clinic name: Phone: |  **Yes No****(allergies continued)**Iodine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Y N Any other drugs\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Y N Metal(s) Specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Y N Food(s) Specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Y N Other(s) Specify: 8) Do you use drugs or other substances for recreational purposes?....................... Y N  Frequency or use (daily, weekly, etc): \_\_\_\_\_\_\_\_\_\_\_Are you drug dependent?............................................. Y N  Number of years of recreational drug use?\_\_\_\_\_\_\_\_If yes, are you receiving treatment?......................... Y N Do you smoke, use smokeless tobacco or vape?.......................................................... Y N  If yes, type, how much/often, packs per day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_If yes, how interested are you in stopping?................ Y N  |
| 1. Has a previous physician dentist

recommended that you take anti-biotics prior to your dental treatment?........................................................................ Y N  Name of referring Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number: |
| 1. Have there been any changes in

your general health within the past year?......................................................... Y N  If yes, please explain? |
| 1. Have you had any serious illness,

operation, organ transplant or beenhospitalized in the past 5 years?................................... Y N If yes, Illness or problem? | **For Children:** History of finger, thumb, blanket orpacifier sucking.............................................................. Y NHistory of dental anxiety?............................................ Y NAny other oral habits (specify): |
| 1. Do you drink alcoholic beverages?.......... Y N

If yes, how much do you typically drink in a week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you alcohol dependent?............................. Y NIf yes are you receiving treatment?.................. Y N | **WOMEN ONLY**Are you or could you be pregnant?.................................................................... Y N Number of weeks:\_\_\_\_\_\_\_\_\_\_\_\_Nursing?.................................................................... Y N Taking birth control pills or hormonal replacement?........................................... Y N  |
| 1. Have you had cancer, tumor,

or malignancy?............................................................. Y N  If yes, type, when, treatment? |

**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 inquires 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.

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| --- | --- | --- |
| Signature of Patient/Legal Guardian: | Today’s Date: | Doctor’s signature: |

First review date:\_\_\_\_\_\_\_\_\_\_\_ Patient signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Doctor’s signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Second review date:\_\_\_\_\_\_\_\_\_\_\_ Patient signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Doctor’s signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Third review date:\_\_\_\_\_\_\_\_\_\_\_ Patient signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Doctor’s signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

