HEALTH HISTORY

_____ _____

PATIENT'S NAME **DATE**

Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health?.....Y N
2. Has there been any change in your general Health this past year?.....Y N
3. Date of last physical exam_____
4. Are you now under a physician's care for A particular problem?.....Y N
5. Have you **ever** had any serious illnesses, operations, Or hospitalizations? If so, describe.....Y N

_____

_____

6. Height_____Weight_____
7. **Do You Have OR Have You Ever Had:**
   - A. Rheumatic fever or Rheumatic Heart Disease?....Y N
   - B. Congenital Heart Disease?.....Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Mitral Prolapse, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?.....Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)?.....Y N
   - E. Seizures, Convulsions, Fainting, Dizziness or Severe Headaches?.....Y N
   - F. Bleeding Disorder, Anemia, Sickle Cell, Bleeding Tendency, Blood Transfusion, Bruise easily?..... Y N
   - G. Liver Disease (Jaundice, Hepatitis)?.....Y N
   - H. Kidney Disease?.....Y N
   - I. Diabetes?.....Y N
   - J. Thyroid Disease (Goiter)?.....Y N
   - K. Arthritis?.....Y N
   - L. Stomach Ulcers, Colitis or Acid Reflux?.....Y N
   - M. Glaucoma?.....Y N
   - N. Implants placed anywhere in the body (Heart Valve, Pacemaker, Hip, Knee)?.....Y N
   - O. Radiation (X-Ray) or Chemo (Chemical) Therapy for Cancer? ..... Y N
   - P. Clicking or Popping of jaw joint, pain near ear, Difficulty opening mouth, grind or clench teeth?...Y N
   - Q. Sinus of Nasal problems?.....Y N
   - R. Any disease, drug or transplant Operation that has Depressed your Immune System?.....Y N
   - S. Venereal Disease?.....Y N
   - T. Sleep Disorder?.....Y N
8. **Are You Using Any of the Following:**
   - A. Antibiotics?.....Y N
   - B. Anticoagulants (Blood Thinners) ?.....Y N
   - C. Aspirin, such as Motrin, Aleve, Ibuprofen?.....Y N
   - D. Steroids (Cortisone, Etc.)?.....Y N
   - E. Tranquilizers?.....Y N
   - F. Digitalis,Inderal,Nitroglycerin or other heart drug?.Y N
   - G. Please list or attach, any & all medications you are Now taking, including prescription & over the counter Medications, vitamins, minerals, and herbal or holistic Remedies:_____
     _____
     _____
     _____
9. **Are you Allergic to or have had an adverse Reaction to:**
   - A. Local Anesthesia (Novocaine, etc.)?.....Y N
   - B. Penicillin or other Antibiotics?.....Y N
   - C. Sedatives or barbiturates?.....Y N
   - D. Aspirin or Ibuprofen?.....Y N
   - E. Codeine or other pain killers?.....Y N
   - F. Latex or rubber products?.....Y N
   - G. Egg or soy?.....Y N
   - H. Other Allergies or reactions? Please list:.....Y N

     _____
10. Do you smoke or chew tobacco?.....Y N
11. Is there any past history of alcohol or chemical Dependency or emotional disorder that may affect the Care we provide to you?.....Y N
12. Have you had any serious problems associated with Any previous dental treatment?.....Y N
13. Have you or an immediate family member had any Problem associated with General Anesthesia?.....Y N
14. Do you have any other disease, condition or problem Not listed above?.....Y N
    Please list: _____
15. Do you wish to talk to the doctor privately about Anything?.....Y N
16. **For Women Only**
    - A. Are you pregnant or **is there any chance** you may Be pregnant?.....Y N
    - B. Are you Nursing?.....Y N
    - C. **If you are using oral contraceptives,** it is important That you understand that antibiotics & some other Medications, may interfere with the effectiveness of Oral contraceptives. Therefore, you will need to use Mechanical forms of birth control for one complete Cycle after the course of antibiotics or other Medications are completed. Please consult with Your Physician for further Guidance.

I understand to importance of a truthful Health History, to assist the doctor in providing the best care possible. I have had the opportunity to discuss this with my doctor.

_____ _____ _____

Date **Signature of person completing health history** **Doctor's Initials**

_____

Staff Initials