Health History

Patient's Name____

How long has it been since: Your last check up?__________________________

X-Rays?_________________________________

Cleaning?________________________________

Previous Dentist____

Physician's Name________________________Phone # ________________________

Date of last physical exam____

Have you been admitted to a hospital or needed emergency care during the past two years? If yes, please explain____

Please list all medications, drugs or pills you are taking and the dosage amounts and times you take them. Include supplements, herbs, vitamins and over the counter pill, etc.

Please list any medications or substances you have had an allergic reaction to or reacted adversely to ____

So that we may address your most urgent needs in a timely manner, please indicate your chief concern, complaint or request:____

Is there anything you would like to change about your smile or appearance of your teeth?

Have you heard of dental whitening or power bleaching? Yes________No________

Do you have any interest in having whiter teeth? Yes________No________

Have you needed N2O or IV Sedation for dental treatment before? Yes_____No_____

Please check the following conditions you have or have had

Yes No

____ ____Alcoholism

____ ____Anemia

____ ____Arthritis

____ ____Artificial Heart Valve

____ ____Prior history of infective bacterial endocarditis

____ ____Artificial Joints. When was your prosthetic joint placed?__________

____ ____Has your prosthetic joint been infected before?

____ ____Diabetes: Type?__________ How often do you test?__________

What is your HgA1C_________%? When was it last tested?_____

____ ____Have you ever lost consciousness from low blood sugar?

____ ____Diabetic associated eye disease

____ ____Peripheral Neuropathy

____ ____Rheumatoid Arthritis

____ ____Immune Suppressed

____ ____Hemophilia

____ ____Blind

____ ____Blood Thinners

____ ____Cold Sores/Fever Blisters

____ ____Developmentally Disabled

Yes No

____ ____Excessive Bleeding
____ ____Fainting or Dizziness
____ ____Hay Fever
____ ____Head Injury
____ ____Hearing Impairment
____ ____Latex Allergy
____ ____Liver Disease
____ ____Have you been diagnosed with any nervous disorder or psychosis such as OCD or Schizophrenia?
____ ____Respiratory Problems
____ ____Sinus Problems
____ ____Tuberculosis
____ ____Ulcers
____ ____Venereal Disease
____ ____Do you drink or consume grapefruit in any form?
____ ____ Do you take Plavix?
____ ____HIV or AIDS: Treating Dr.'s Name____________________________Phone________________
____ ____ Do you take protease inhibitors?
____ ____ Do you take antifungal agents?
____ ____Kidney Disease: In Dialysis? Yes____No____ Which arm is your port in?________________
____ ____Pacemaker: What year was it placed? __________
Do you have to avoid microwave ovens? Yes____No____
____ ____Previous fainting in Dental Office
____ ____Recovering Drug Addict
____ ____Recreational Drug Use: What are you taking? ____
____ ____Glaucoma
____ ____Acute Narrow Angle Glaucoma
____ ____Chronic Bronchitis
____ ____Emphysema
____ ____Asthma
How often do you have attacks?____
What brings on the Asthma attack?____
What do you use to correct the problem?____
____ ____Have you ever been hospitalized because of your Asthma?
____ ____COPD
____ ____Obstructive Sleep Apnea
____ ____Cancer: When Diagnosed? ___________Type and/or Location__________________________
How was it treated?____
____ ____Epilepsy or Seizures: Date of last seizure____
Frequency per month or year?____
____ ____Hard to get Numb: Top__________ Bottom__________
____ ____Hepatitis: Type? _______________
Do you have associated Liver problems? Yes____No____
Have you had Jaundice? Yes____No____If yes, Date__________________________
____ ____Pregnancy-Due Date? ____________________________
____ ____Is there a chance you might be pregnant?
____ ____Are you planning on getting pregnant?
OB Name____
OB Phone #____
____ ____Hyperlipidemia; What is your total cholesterol?________HDL_______LDL________

Yes No

____ ____Angina/Chest Pain: Nitroglycerine pills or spray? Yes____No____
If so, how frequent. ____

____ ____ Has the pattern of your angina changed?________________________

____ ____Do you have angina at rest?

____ ____Have you had recent changes in your angina medication?____________________________

____ ____Heart Disease

____ ____Congestive Heart Failure

____ ____Arrhythmia. Type?________________

____ ____High Blood Pressure

____ ____Have you had a Heart Attack or MI? Date_____________________________

____ ____Have you had a Cardiac Stent placed? Date____________________________

____ ____Is it a Drug Elutting Stent also known as DES?

____ ____Have you had a Stroke? Date______________________

____ ____Congenital heart disease including: unrepaired cyanotic congenital heart disease which includes palliative shunts or conduits?

____ ____Completely repaired congenital heart defect with prosthetic material or device placed by either surgery or catheter within the last 6 months?

____ ____Repaired congenital heart disease with residual defects at the site or adjacent to the site of a Prosthetic patch or prosthetic device which inhibits endothelialization?

____ ____Have you had a heart transplant that has developed valvulitis?

____ ____Do you use Tobacco products?
Smoke?_____How many packs per day?_________For how many years?______________
Smokeless?_____How many times per day?_________For how many years?____________

____ ____ Have you taken Phen Fen/Redux?

Other-Describe any other medical conditions or problems:
____
____

BISPHOSPHONATES

Are you currently or have you previously taken any of the drugs listed below?
If yes, check the medication below and indicate the mg. dosage and how often taken.

BRAND NAME/GENERIC NAME

Orally Administered Bisphosphonates:

Actonel/ Risedronate ___________________
Boniva/ Ibandronate ___________________
Fosamax/Alendronate ___________________
Fosamax Plus D/Alendronate ___________________
Skelid/Tiludronate ___________________
Didronel/Etidronate ___________________

Intravenously Administered Bisphosphonates:

Aredia/Pamidronate ___________________
Zometa/Zolendronic Acid ___________________
Bonefos/Clodronate ___________________

To the best of my knowledge, all of the preceding answers and information are true and correct. I authorize the dentist to release any information including diagnosis and the records of any treatment rendered to me or my child to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist.

______________________________ __________ ______________ __________
Signature of Patient, Parent or Guardian Date Reviewed by Doctor Date