CONFIDENTIAL HEALTH HISTORY

Patient Information

Patient Name: ______ Date Of Birth: ______

CHECK APPROPRIATE ANSWER *(Leave blank if you do not understand the question)*

☐ Yes ☐ No Is your general health good?

If NO, explain

☐ Yes ☐ No Has there been a change in your health within the last year?

If YES, explain

☐ Yes ☐ No Are you being treated by a physician now?

If YES, explain

Name of physician ______

Date of last medical examination ______

HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? *(Please Check)*

- ☐ Damaged heart valve
- ☐ Pacemaker
- ☐ Headaches/ migraines
- ☐ Digestive problems
- ☐ Kidney disease
- ☐ Hay Fever
- ☐ Emphysema
- ☐ Chemotherapy or radiation
- ☐ HIV or AIDS
- ☐ Chemical dependency
- ☐ Seizures
- ☐ Cosmetic surgery
- ☐ Artificial heart valve
- ☐ High blood pressure
- ☐ Blood disorder
- ☐ Eating disorder
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Lung disease
- ☐ Arthritis
- ☐ Sexually transmitted disease
- ☐ Alcohol dependency
- ☐ Herpes
- ☐ Stent
- ☐ Heart attack/ disease
- ☐ Stroke
- ☐ Hepatitis/ liver disorder
- ☐ Acid reflux disease
- ☐ Asthma
- ☐ Persistent Cough
- ☐ Cancer/ tumor
- ☐ Skin disease
- ☐ Psychiatric problems
- ☐ Tobacco habit
- ☐ Artificial joint

Describe any surgeries you have had.

☐ Yes ☐ No Have you been diagnosed with sleep apnea?

○ Yes ○ No Do you have a CPAP machine?
○ Yes ○ No If you do have a CPAP machine, are you comfortable with it?

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? *(Please Check)*

- ☐ Aspirin
- ☐ Latex
- ☐ Codeine
- ☐ Penicillin
- ☐ Local anesthetic
- ☐ Food
- ☐ Antibiotics
- ☐ Novacaine

Other Allergies

MEDICATIONS AND PRESCRIPTIONS

Please list supplements, prescription or recreational drugs you are taking

ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? *(Please Check)*

- ☐ Recreational drugs
- ☐ Aspirin
- ☐ Fosomax
- ☐ Reclast
- ☐ Skelid
- ☐ Tobacco in any form
- ☐ Coumadin
- ☐ Actonel
- ☐ Didronel
- ☐ Antibiotics
- ☐ Plavix
- ☐ Boniva
- ☐ Zometa

ALL PATIENTS

○ Yes ○ No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If Yes, explain

○ Yes ○ No Have you ever been pre-medicated for dental treatment?
If Yes, explain

○ Yes ○ No Have you ever taken Fen-phen?
If Yes, explain

○ Yes ○ No Is there any issue or condition that you would like to discuss with the dentist in private?

WOMEN ONLY

○ Yes ○ No Are you or could you be pregnant?
○ Yes ○ No Are you nursing?
○ Yes ○ No Are you taking birth control pills?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potential medically- compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the dentist to contact my physician. I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

SIGNATURE

Signature of Patient *(Type Adult name here)* ____________________ Date __________