PATIENT _____ DATE _____

HEALTH HISTORY

Date of Last Health Care Exam: _____ What was this exam for? _____
When was your last dental exam? _____ (Year)
Have you been hospitalized or had surgery? (Please circle) Y N If yes, reason: _____
Are you currently receiving care? Y N If yes, nature of care: _____
Please list all the names and phone numbers of the physicians who are currently providing you care:

1. Name _____ Phone Number _____
2. Name _____ Phone Number _____
3. Name _____ Phone Number _____
4. Name _____ Phone Number _____

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.

Blood Disorders	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease	No	Yes	Joint Replacement	No	Yes
Asthma, COPD or other Lung Diseases	No	Yes	If yes, when was it placed?		
Abnormal Bleeding from a cut	No	Yes	Kidney Disease	No	Yes
Cancer or Tumor	No	Yes	Liver Disease (including Jaundice)	No	Yes
If yes, what type of Cancer?			Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Heart murmur	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Psychiatric Therapy	No	Yes
Epilepsy	No	Yes	Previous Biopsies	No	Yes
Fainting or Dizzy Spells	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Glaucoma	No	Yes	Renal Dialysis	No	Yes
Previous Bacterial Endocarditis	No	Yes	Slow-Healing Mouth Sores	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Congenital Heart Disease	No	Yes	H.I.V. Infection/AIDS	No	Yes
Heart Disease, Heart Attack, Heart Surgery, Angina	No	Yes	Venereal Disease	No	Yes
Heart Stent	No	Yes	Thyroid	No	Yes
If yes, when was it placed?			Recurrent Illnesses	No	Yes
Migraines	No	Yes	Dry mouth	No	Yes
Anemia	No	Yes	Other Conditions	No	Yes
Rheumatic Fever	No	Yes			

Are you taking any of these medications?

Pre-medication before dental treatment	No	Yes	Biaxin® (Clarithromycin)	No	Yes
Antacids	No	Yes	Cardizem® (Diltiazem) or Calan, Isoptin® (Verapamil)	No	Yes
St. John's Wort or Kava-Kava	No	Yes	Barbiturates (any)	No	Yes
Dilantin® or Tegretol®	No	Yes	Diflucan® (Fluconazole) or Sporanox® (Itraconazole)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®, RECLAST) or PROLIA?				No	Yes
If so, when did the treatment begin?			When did the treatment end?		
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

Have you traveled outside of the US recently?	No	Yes	If yes, where?		
Have you been in contact with anyone exposed, suspected to have been exposed, or has been diagnosed with Coronavirus/COVID-19?	No	Yes	Have you recently experienced a fever, cough, or difficulty breathing?	No	Yes

Please list any medications you are currently taking and dosages:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Please list any dietary or herbal supplements you are taking, and for what purpose:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Do you use recreational drugs? Y N If so, which ones? _____

SLEEP

Do you suspect or have you been told that you snore?	No	Yes
Do you suspect or have you been diagnosed with sleep apnea?	No	Yes
Are you being treated for sleep apnea with a CPAP, BiPAP, or other device?	No	Yes

WOMEN

Are you pregnant?	No	Yes
If no, are you planning a pregnancy in the near future?	No	Yes
Are you a nursing mother?	No	Yes
Are you taking birth control pills?	No	Yes

ABNORMAL BLOOD PRESSURE? (PLEASE CIRCLE)

Have you ever received a diagnosis of "high blood pressure" or "low blood pressure"?	No	Yes
What is your normal blood pressure? S /D	Today: _____ / _____	

ARE YOU ALLERGIC OR HAVE YOU HAD A REACTION TO:

A. Local anesthetics or epinephrine	No	Yes
B. Penicillin or other antibiotics	No	Yes
C. Aspirin, Ibuprofen or Tylenol®	No	Yes
D. Codeine, Valium®, Hydrocodone, Oxycodone or other sedatives	No	Yes
E. Latex or Metals		
F. Other (Please Specify) _____		

TOBACCO, ALCOHOL, DRUGS

Do you use tobacco?	No	Yes
If yes, circle type: Smoke Chew How much per day? For how long?		
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol?	No	Yes
If yes, approximately how many alcoholic beverages per week?		
Do you use any mood-altering drugs other than those previously listed?	No	Yes

WEIGHT AND DIET CONSIDERATIONS

Weight	Height	Meals Per Day	Dietary Restrictions	Food Allergies
Sugar in your diet **(Circle One):** None Slight Moderate High				

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

Significant findings from questionnaire or oral interview:

Dental management considerations:

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 any change in my health and medication.

Patient (Print Name)	Patient Signature	Date
Doctor (Print Name)	Doctor Signature	Date