HEALTH HISTORY

Since your well-being is our primary concern, please take the time to accurately answer the following questions.

Name:___________________________________ Age:_____ Sex: M / F **Height:** ___________ **Weight:** __________ Date:_______________

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N) – ALL RESPONSES ARE CONFIDENTIAL

DO YOU HAVE OR HAVE YOU EVER HAD:

Asthma	Y	N	Nose Bleeds or Bruise Easily	Y	N	Hypoglycemia – Low Blood Sugar	Y	N
Emphysema or COPD	Y	N	Anemia	Y	N	Diabetes Type 1 or Type 2 (circle)	Y	N
Severe or Chronic Coughing	Y	N	Pacemaker or Defibrillator (ICD)	Y	N	Dizziness or Fainting	Y	N
Pneumonia	Y	N	Blood Clots	Y	N	Frequent Headaches or Migraines	Y	N
Difficulty Breathing or Shortness of Breath	Y	N	Abnormal Bleeding or Bleeding Disorder	Y	N	Depression / Anxiety	Y	N
Sleep Apnea or breathing problems while sleeping	Y	N	Osteoporosis/Osteopenia	Y	N	Stroke	Y	N
Snoring	Y	N	Infectious Disease	Y	N	Epilepsy / Seizures / Convulsions	Y	N
Sinus / Nasal Problems	Y	N	Heartburn / Reflux	Y	N	Psychiatric Illness	Y	N
Irregular Heartbeat / Palpitations	Y	N	Stomach Ulcers or Colitis	Y	N	Recent Unplanned Weight Loss	Y	N
High Blood Pressure	Y	N	Pancreatitis	Y	N	Glaucoma	Y	N
Low Blood Pressure	Y	N	Liver Disease or Hepatitis or Jaundice	Y	N	Contact Lenses or Glasses	Y	N
Chest Pain or Angina	Y	N	Organ Transplants	Y	N	Thyroid Problems	Y	N
Heart Attack or Heart problems	Y	N	Recurrent infections of any kind	Y	N	TMJ problems (jaw joint pain or difficulty opening mouth)	Y	N
Heart Failure / Congestive Heart Failure	Y	N	Tumor	Y	N	Clenching / Grinding teeth	Y	N
Heart Murmur / Valve Problems	Y	N	Cancer	Y	N	Arthritis	Y	N
Artificial Heart Valves	Y	N	Radiation Therapy or Chemotherapy	Y	N	Back Pain	Y	N
Rheumatic Fever or Rheumatic Heart Disease	Y	N	Immune Deficiency	Y	N	Fibromyalgia	Y	N
Family History of Heart Disease, Blood clot or Stroke below the age of 40?	Y	N	Any disease or drug that has suppressed your immune system?	Y	N	Implants or Artificial Joints placed anywhere in your body (heart valve, hip, knee, etc)	Y	N
History of slow wound healing?	Y	N	Kidney Disease	Y	N	Numbness	Y	N
			Dialysis	Y	N			

ADDITIONAL HEALTH QUESTIONS:

Do you now or did you ever use tobacco? How much per day? ______________ Date Quit:________	Y	N	Have you ever had a difficult extraction or dry socket?	Y	N	Have you ever had any complications with any surgery, anesthesia or sedation?	Y	N
Do you use alcohol? How much? ___________________	Y	N	Have you had any adverse effects from dental treatment?	Y	N	Do you or a family member have any history of Malignant Hyperthermia (life threatening reaction to general anesthesia)?	Y	N
Any history of Alcohol or Drug Abuse?	Y	N	Has there been any change in your general health in the past year?	Y	N	Are you in good health?	Y	N
Have you ever suffered a serious head injury or facial injury?	Y	N				Are you now under a physician's care for a particular problem?	Y	N

Have you **<u>ever had ANY surgery, serious illnesses, or hospitalizations</u>**? If yes, Explain:____

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Do you have **<u>any other condition</u>** or problem not listed on this page? Explain:____

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MEDICATIONS: Are you taking any of the following (Currently or within 2 years) ?

Inhalers	Y	N	Have you taken cortisone, prednisone or other steroid drugs in the past two years?	Y	N	Digitalis, Inderal, Nitroglycerin, Calcium Channel Blockers, Procardia, or other HEART Medicine	Y	N
Have you ever had BONE medications for osteoporosis, multiple myeloma or cancer treatment?	Y	N	Prolia, Denosumab, Xgeva, Zometa, Zoledronate, Reclast	Y	N	Fosamax, Alendronate, Actonel, Risedronate, Boniva, Ibandronate, Aredia, Aredia, Pamidronate	Y	N
Antibiotics	Y	N	Marijuana	Y	N	Valium or other tranqulizers	Y	N
Anticoagulants (Blood thinners)	Y	N	Other recreational drugs?	Y	N	Chronic Pain medications	Y	N
High Blood Pressure Medicine	Y	N	Are you taking any other regular medications, pills or drugs?	Y	N	Do you have a pain contract / narcotic contract	Y	N

Please **LIST ANY AND ALL MEDICATIONS YOU ARE CURRENTLY TAKING (names only)**:

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ALLERGIES or REACTIONS: <u>Please CIRCLE any below medications to which you are Allergic or have had a reaction:</u>

Local Anesthetic	Dental Injections	Penicillin	Amoxicillin	Cephalosporins	Sulfa	Codeine
Tetracycline	Morphine	Iodine	Barbiturates	Sedatives	Aspirin	Latex
Clindamycin	Ibuprofen	Chemicals	Jewelry/Metals	Food products	Other Allergies	

Please list allergies here if not listed specifically above: ______________________________

FOR WOMEN ONLY:

Are you pregnant or is there any chance you might be pregnant?	Y	N	Are you nursing?	Y	N

If you are using oral contraceptives, it is important to understand that antibiotics may interfere with the effectiveness of oral contraceptives. Therefore you will need to use an alternative form of birth control for one complete cycle after the course of antibiotics. Consult with your physician for further guidance. If you are pregnant, or trying to become pregnant, surgery or anesthetics may harm your baby in the first trimester. Please advise your physician if there is any chance of your being pregnant.

FOR EVERYONE:

I hereby certify that the answers I have given to the above questions are true & correct to the best of my knowledge. I will not hold my surgeon, or any member of their staff, responsible for any errors or omissions that I may have made in the completion of this form. I will notify the Doctor of any changes in my health status while under his care. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Date ______________________ **Signature** (Guardian if minor) ______________________________

FOR COMPLETION BY THE SURGEON <u>Comments on patient interview concerning medical history:</u>

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Dental Management Considerations: ____

Date: ________________ Surgeon’s Signature: ___________________________________