PATIENT HEALTH HISTORY

Patient's Name: _____ Date of Birth: _____

ANSWER ALL QUESTIONS BY CIRCLING YES (Y) or NO (N)

1. Are you in good health ..... Y N
2. Has there been any changes in your health over the past year? ..... Y N
3. Date of last physical exam: _____
4. Are you now under a physician's care ..... Y N
5. Have you ever had a serious illness ..... Y N

(PLEASE LIST ON REVERSE SIDE)

1. DO YOU HAVE OR HAVE YOU EVER HAD:

A. Rheumatic Fever or Rheumatic Heart Disease ..... Y N
B. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? ..... Y N
C. Lung Disease (Asthmas, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing? ..... Y N
D. Seizures, Convulsion, Epilepsy, Fainting or dizziness? ..... Y N
E. Bleeding Disorder, Anemia, and Bleeding Tendency, Transfusion? Do you bruise easily? ..... Y N
F. Liver Disease? ..... Y N
G. Kidney Disease? ..... Y N
H. Diabetes? ..... Y N
I. Thyroid Disease (Goiter)? ..... Y N
J. Arthritis? ..... Y N
K. Stomach Ulcers or Colitis? ..... Y N
L. Glaucoma? ..... Y N
M. Osteoporosis? ..... Y N
N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
O. Radiation (X-ray) treatment 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 or Nasal problems? ..... Y N
R. Any disease, drug or transplant operation that has depressed your immune system? ..... Y N

2. ARE YOU USING ANY OF THE FOLLOWING?

A. Antibiotics? ..... Y N
B. Anticoagulants (blood thinners)? ..... Y N
C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? ..... Y N
D. High Blood Pressure medications? ..... Y N
E. Steroids/Cortisone, Prednisone, etc.? ..... Y N
F. Tranquilizers? ..... Y N
G. Insulin or Oral Anti-Diabetic drugs? ..... Y N
H. Digitalis, Nitroglycerin or other heart drugs? ..... Y N

ALL RESPONSES ARE CONFIDENTIAL

I. Are you taking ***or have you ever taken***: Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax Actonel, Boniva, Aredia, Zometa)? ..... Y N
J. Have you ever been advised not to take any medication? ..... Y N
K. Please list any and all medications taken including prescription medications, diet, drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:

(PLEASE LIST ON REVERSE SIDE)

3. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:

A. Local Anesthesia (Novocain, etc.)? ..... Y N
B. Penicillin or other antibiotics? ..... Y N
C. Sedatives, 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. Metal of any kind? ..... Y N
H. Chemicals or jewelry (rash/sensitivity)? ..... Y N
I. Food products? ..... Y N
J. Other allergies or reactions? ..... Y N

(PLEASE LIST ON REVERSE SIDE)

1. Do you smoke or chew Tobacco? ..... Y N
2. How much per day? _____
3. Is here any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you? ..... Y N
4. Have you had any serious problems associated with any previous dental treatment? ..... Y N
5. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N
6. Do you wish to talk with the doctor privately about anything? ..... Y N

FOR WOMEN ONLY:

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

IMPORTANT NOTICE

If you are using Oral Contraceptives, it is important that you understand that antibiotics (and 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 of birth control pills, after the course of antibiotics or other medication is completed. Please consult your Physician for further guidance.

I understand the importance of a truthful and complete Health History to assist my dentist in providing me the best care possible. I have had the opportunity to discuss my Health History with my dentist.

Signature of Person Completing Health History Date Doctor's Initial

Have you ever had any serious illnesses, surgery or hospitalizations? If so, describe:

Please list any and all medications taken including, prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or mineral:

Please list all allergies or reactions you have had to any medications:

Additional information (if you entered YES to any of the questions on page 1, please describe in detail below:

Physician's Name: _____

Physician's telephone No.: _____