 **Health History**

| Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Physician’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| --- | --- |

**Please circle Yes (Y), No (N) for your responses(s) to indicate if you have or have not had any off the following diseases or problems**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Cardiovascular** |  |  | **If yes, please specify** | **Neurologic** |  |  | **If yes, please specify** |
| Blood thinner (please select type)   1. Asprin (F) Pradaxa 2. Plavix (G) Effient 3. Eliquis (H) Brilinta 4. Xarelto (I) Savaysa 5. Coumadin/ (J) Other   Warfarin | Y | N |  | Fainting spells | Y | N | When |
| High/Low Blood Pressure | Y | N | Circle one:  High Low | Stroke/CVA | Y | N | Type |
| Congestive heart failure | Y | N | When | Neuralgia | Y | N |  |
| Rheumatic heart disease | Y | N | When | Shingles | Y | N |  |
| Angina or chest pain | Y | N | Type | Seizures/epilepsy | Y | N | Last time? |
| Heart surgery | Y | N | When | Paralysis | Y | N |  |
| Coronary bypass surgery | Y | N | Date | Glaucoma | Y | N |  |
| Stents | Y | N | Date | Hearing loss | Y | N |  |
| Myocardial infarction (heart attack) | Y | N | When | Severe headaches | Y | N |  |
| Pacemaker defibrillator | Y | N | When | **Gastrointestinal/Liver** |  |  | **If yes, please specify** |
| Arrhythmias/Atrial fibrillation | Y | N |  | Stomach Ulcers | Y | N |  |
| Aneurysm | Y | N |  | Gastritis | Y | N |  |
| Shortness of breath | Y | N |  | GERD/Reflux | Y | N |  |
| Swollen ankles | Y | N |  | Hepatitis | Y | N | Type |
| **Cardiac Reasons For Pre-medication** | | | |  |  |  |  |
| **Have you had a heart transplant?** | **Y** | **N** | **Date:** |  |  |  |  |
| **Have you had an artificial heart valve?** | **Y** | **N** | **Date:** |  |  |  |  |
| **Previous infective endocarditis** | **Y** | **N** |  | Liver disease | Y | N | When |
| **Damaged valves in transplanted heart** | **Y** | **N** |  | Jaundice | Y | N |  |
| **Congenital heart disease (CHD)** | **Y** | **N** |  | Cirrhosis | Y | N |  |
| **Unrepaired cyanotic (CHD)** | **Y** | **N** |  | History of C. difficile | Y | N | When |
| **Repaired (completely) in last 6 months** | **Y** | **N** |  | Chron’s disease  Ulcerative Colitis | Y  Y | N  N | When  When |
| **Repaired CHD with residual defects** | **Y** | **N** |  |
| **Hematologic** |  |  | **If yes, please specify** | **Respiratory** |  |  | **If yes, please specify** |
| Blood transfusion | Y | N | When | Emphysema | Y | N | O2 Therapy? |
| Anemia | Y | N |  | Bronchitis | Y | N |  |
| Hemophilia | Y | N |  | Tuberculosis | Y | N |  |
| Leukemia | Y | N | When | Sleep disorders | Y | N |  |
| Sickle cell disease | Y | N | Type |
| **Immune System** |  |  | **If yes, please specify** | (Musculoskeletal continued)  Osteopenia or osteoporosis | Y | N |  |
| HIV positive | Y | N |  | Are you or have you taken an anti-  resorptive agent for osteoporosis  or Paget’s disease?.......................................... Yes No  If yes, please select from the following:  Oral Bisphosphonate  (Actonel/Boniva/Fosamax/Atelvia) □  Or  IV Bisphosphonate  (Aredia/Zometa/Bonefos/Reclast/Prolia) □ | | | |
| Sjogren’s syndrome | Y | N |  | **Endocrine** |  |  | **If yes, please specify** |
| Genitourinary | Y | N | If yes, please specify | Diabetes  A1C ≥ 6 in the past 12 months? | Y  Y | N  N |  |
| Kidney problems | Y | N | Kidney problems | Thyroid disease | Y | N |  |
| Taking or ever taken steroids? | Y | N | How long? |
| Other | Y | N |  |
| Dialysis | Y | N |  | **Orthopaedic Joint Replacement** | | | |
| Sexually transmitted disease | Y | N |  | **Have you had an orthopaedic total joint (hip, knee, elbow, shoulder replacement?....................................... Yes No**    **Date of implant:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| Human papilloma virus (HPV) positive | Y | N |  |
| Other | Y | N | Specify | **Have you had a joint replacement**  **in the last 6 months?.............................................. Yes No** | | | |
| **Musculoskeletal** |  |  | **If yes, please specify** | **Have you been advised to pre-medicate**  **for joint replacement……..……………………… Yes No** | | | |
| Arthritis | Y | N | Arthritis | **Do you have history of infections**  **with joint replacement?............................................ Yes No** | | | |
| Bone disorder | Y | N | Bone disorder | **Have you been told you are immuno-**  **Compromised……………………………………….. Yes No**  **Orthopaedic surgeon’s name:**  **Phone #:** | | | |
| Muscle disorder | Y | N |  |
| Rheumatoid Arthritis | Y | N | Iv infusions? |
| Immunosuppressant drugs | Y | N |  |
| Systemic lupus erythematosus | Y | N |  |

|  |  |
| --- | --- |
| **Yes No**   1. Are you in good health?.................................... Y N   If no or don’t know, please explain?  Allergies: Are you allergic to  or have you had a reaction to any of the following?  **To all yes response, specify types**  **of reaction.**  Latex\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Y N  Penicillin\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Y N  Other antibiotics\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Y N  General anesthetics\_\_\_\_\_\_\_\_\_\_\_\_ Y N  Local anesthestics\_\_\_\_\_\_\_\_\_\_\_\_\_ Y N  Aspirin\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Y N  Codeine or other narcotics\_\_\_\_\_\_ Y N   1. Are you now under the care   of a physician?.................................................... Y N  If yes, what is/are the conditions being treated?  Physician or Clinic name: Phone: | **Yes No**  **(allergies continued)**  Iodine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Y N  Any other drugs\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Y N  Metal(s) Specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Y N  Food(s) Specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Y N  Other(s) Specify:  8) Do you use drugs or other  substances for recreational purposes?....................... Y N    Frequency or use (daily, weekly, etc): \_\_\_\_\_\_\_\_\_\_\_  Are you drug dependent?............................................. Y N    Number of years of recreational drug use?\_\_\_\_\_\_\_\_ If yes, are you receiving treatment?......................... Y N  Do you smoke, use smokeless  tobacco or vape?.......................................................... Y N    If yes, type, how much/often, packs per day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If yes, how interested are you in stopping?................ Y N |
| 1. Has a previous physician dentist   recommended that you take anti-  biotics prior to your dental  treatment?........................................................................ Y N    Name of referring Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone Number: |
| 1. Have there been any changes in   your general health within the  past year?......................................................... Y N    If yes, please explain? |
| 1. Have you had any serious illness,   operation, organ transplant or been  hospitalized in the past 5 years?................................... Y N  If yes, Illness or problem? | **For Children:**  History of finger, thumb, blanket or  pacifier sucking.............................................................. Y N  History of dental anxiety?............................................ Y N  Any other oral habits (specify): |
| 1. Do you drink alcoholic beverages?.......... Y N   If yes, how much do you typically  drink in a week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Are you alcohol dependent?............................. Y N  If yes are you receiving treatment?.................. Y N | **WOMEN ONLY**  Are you or could you be  pregnant?.................................................................... Y N  Number of weeks:\_\_\_\_\_\_\_\_\_\_\_\_  Nursing?.................................................................... Y N  Taking birth control pills or  hormonal replacement?........................................... Y N |
| 1. Have you had cancer, tumor,   or malignancy?............................................................. Y N    If yes, type, when, treatment? |

**NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

|  |  |  |
| --- | --- | --- |
| Signature of Patient/Legal Guardian: | Today’s Date: | Doctor’s signature: |

First review date:\_\_\_\_\_\_\_\_\_\_\_ Patient signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Doctor’s signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Second review date:\_\_\_\_\_\_\_\_\_\_\_ Patient signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Doctor’s signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Third review date:\_\_\_\_\_\_\_\_\_\_\_ Patient signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Doctor’s signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

