HEALTH HISTORY FORM (CONFIDENTIAL)

Mr. Mrs. Ms. Dr.

Name _____ Address _____
Last First Number & Street

Tel # (Home) _____ (Cell) _____ City _____ State _____ Zip _____

Date of Birth _____ Sex _____ Height _____ Weight _____ lbs. Email _____
Social Security No. _____ Single ❑ Married ❑ Name of Spouse _____
Closest Relative _____ Phone _____ Referring Dentist _____
If you are completing this form for another person, what is your relationship to that person? _____

For the following questions, circle **YES** or **NO**. Your answers are for our records only and will be considered confidential.

1. Are you in good health? ..... YES NO
2. Has there been any change in your general health within the past year? ..... YES NO
3. My last complete physical exam was on _____
4. Are you now under the care of a physician? ..... YES NO
   If yes, what is the condition being treated? _____
5. The name, city, and state of my physician is _____ Phone _____
   _____ Fax _____
6. Have you had any illness or operation that required hospitalization? ..... YES NO
   If so, what was the illness or operation? _____

Do you have or have you had any of the following diseases or problems? PLEASE CIRCLE

7. Damaged heart valves, artificial heart valves, knee or hip replacement, plastic or artificial arteries? ..... YES NO
8. Congenital heart defect(s) or murmur? ..... YES NO
9. Cardiovascular disease: heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure (hypertension), arteriosclerosis, or stroke? Please circle ..... YES NO
   a. Do you have chest pain upon exertion? ..... YES NO
   b. Are you ever short of breath after mild exercise? ..... YES NO
   c. Do your ankles swell? ..... YES NO
   d. Do you get short of breath when you lie down, or do you require extra pillows when you sleep? ..... YES NO
   e. Do you have a cardiac pacemaker? ..... YES NO
   f. Do you have an arrhythmia or an irregular heart beat? ..... YES NO
10. Has your **physician** ever told you to take antibiotics prior to dental therapy for a medical condition? ..... YES NO
    If YES, why? _____
11. Artificial joints? ..... YES NO
12. Have you ever had Kawasaki's disease, Rheumatic fever, or Scarlet fever? ..... YES NO
13. Sinus trouble? ..... YES NO
14. Asthma, hay fever, hives, or skin rash? (circle which one) ..... YES NO
15. Fainting spells, seizures, or epilepsy? If YES, state cause: ..... YES NO
16. Diabetes? Thyroid, pituitary, or adrenal gland condition? ..... YES NO
17. Is your mouth frequently dry or do you urinate more than six times per day? ..... YES NO
18. Hepatitis, jaundice, or liver disease? ..... YES NO
19. Have you ever been told not to donate blood? If YES, why? ..... YES NO
20. AIDS or tested positive for HIV? ..... YES NO
21. Arthritis or inflammatory rheumatism? ..... YES NO
22. Stomach ulcers? ..... YES NO
23. Kidney trouble? ..... YES NO
24. Tuberculosis or a persistent cough or cough up blood? ..... YES NO
25. Low blood pressure? ..... YES NO
26. Have you ever had venereal disease (syphilis, gonorrhea)? ..... YES NO
27. Have you ever had a nervous breakdown or psychotherapy? ..... YES NO
28. Do you have a history of alcoholism or drug dependence? ..... YES NO
29. Other: _____
30. Have you ever taken any "recreational" drugs in the past such as cocaine, crack, marijuana, LSD? ..... YES NO
    a. If yes, what? _____ When? _____
31. Do you have a history of smoking? ..... YES NO
    a. If yes, how much per day? _____ How many years have you smoked? _____

32. Do you have a history of drinking alcohol?..... YES NO
    a. If yes, how much do you drink **per day** averaged over the week?_____
33. Do you bleed or bruise easily? Or do you have hemophilia or Von Willebrand Disease?..... YES NO
34. Do you have any blood disorder, such as anemia or sickle cell anemia?..... YES NO
35. Have you ever received a blood transfusion?..... YES NO
36. Have you had surgery, x-ray treatment, or chemotherapy for a tumor, cancer, or any other condition?..... YES NO
37. Are you allergic or have you reacted adversely to :
    a. Local or general anesthesia (which one?)..... YES NO
    b. Penicillin or other antibiotics..... YES NO
    c. Sulfa drugs..... YES NO
    d. Barbiturates, sedatives, Valium, Demerol, codeine, or sleeping pills (which one?)..... YES NO
    e. Aspirin, Advil, or Ibuprofen..... YES NO
    f. Iodine..... YES NO
    g. Eggs or egg products..... YES NO
    h. Any other?..... YES NO
38. To the best of your knowledge, has any blood relative had a bad reaction to any anesthetic?..... YES NO
39. Have you ever had any trouble associated with any previous surgery or anesthetic not mentioned?..... YES NO
    a. If YES, what? _____
40. Are you taking, or have you EVER taken, the diet drugs flenfluramine or dexfenfluramine? (fen-phen)..... YES NO
41. Do you have any disease, condition, or problem not mentioned above?..... YES NO
    a. If YES, what? _____
42. WOMEN:
    a. Is there any possibility that you are pregnant?..... YES NO
    b. Are you a nursing mother?..... YES NO
    c. Do you have any problems associated with your menstrual period?..... YES NO
43. Are you taking any of the following?
    a. Antibiotics or sulfa drugs..... YES NO
    b. Anticoagulants (blood thinners)..... YES NO
    c. Medicine for high blood pressure (hypertension)..... YES NO
    d. Cortisone (steroids)..... YES NO
    e. Tranquilizers..... YES NO
    f. Antihistamines..... YES NO
    g. Aspirin or Ibuprofen..... YES NO
    h. Insulin, tolbutamide (Orinase), or similar drug..... YES NO
    i. Digitalis or drugs for heart problems..... YES NO
    j. Nitroglycerin..... YES NO
    k. Oral contraceptive or other hormonal therapy..... YES NO
44. Please list any other prescription AND over-the-counter medications you are taking:

DRUG	DOSE	Reason

I understand that withholding any information about my health could seriously jeopardize my safety. Therefore, I have reviewed this health history carefully and have answered all questions truthfully and to the best of my knowledge.

Signature of Patient (or Guardian) _____ Date _____

Reviewed by: Kathryn M. Le, DDS _____ Date _____