HEALTH HISTORY

Name:_____

Reason for today's visit_____ _____ Previous Dentist and Date____ _____

ARE YOU NOW UNDER THE CARE OF A PHYSICIAN? YES NO

IF SO, WHAT IS THE CONDITION BEING TREATED?_____ _____
NAME AND ADDRESS OF MY PHYSICIAN_____

HAVE YOU HAD ANY SERIOUS ILLNESS, OPERATION OR BEEN HOSPITALIZED IN THE LAST 5 YEARS? N/A YES NO
IF SO, WHAT WAS THE ILLNESS/PROBLEM_____

DO YOU HAVE OR EVER HAD THE FOLLOWING (PLEASE CIRCLE YES or NO FOR EACH QUESTION)

HAVE YOU RECEIVED THE COVID-19 VACCINE? YES NO

HEART MURMUR	YES	NO	CONGENITAL HEART LESIONS	YES	NO
RHEUMATIC FEVER	YES	NO	MITRAL VALVE PROLAPSE	YES	NO
ARTIFICIAL HEART VALVES	YES	NO	SCARLET FEVER	YES	NO
CARDIAC PACEMAKER	YES	NO	HIGH BLOOD PRESSURE	YES	NO
DIABETES	YES	NO	STROKE	YES	NO
HEPATITIS A, B, C	YES	NO	AIDS/HIV	YES	NO
TUBERCULOSIS	YES	NO	SINUS PROBLEMS	YES	NO
ASTHMA	YES	NO	ANEMIA	YES	NO
HEMOPHILIA/BLEEDING DISORDER	YES	NO	EPILEPSY/ OR NEUROLOGICAL DISEASE	YES	NO
FAINTING SPELLS OR SEIZURES	YES	NO	HERPES	YES	NO
KIDNEY TROUBLE	YES	NO	LOW BLOOD SUGAR	YES	NO
PERSISTANT SWOLLEN NECK GLANDS	YES	NO	PROBLEMS WITH MENTAL HEALTH	YES	NO
PROBLEMS WITH IMMUNE SYSTEM	YES	NO	SEXUALLY TRANSMITTED DISEASE	YES	NO
STOMACH ULCER OR HYPERACIDITY	YES	NO	THYROID PROBLEMS (HYPER? Or HYPO?)	YES	NO

RESPIRATORY PROBLEMS, EMPHYSEMA, BRONCHITIS ETC. YES NO

HEART ATTACK	YES	NO	IF YES, WHEN_____
OTHER HEART PROBLEMS	YES	NO	EXPLAIN_____
HEART STENTS	YES	NO	IF YES, WHEN_____
BACTERIAL ENDOCARDIDITS	YES	NO	
PROSTHETIC JOINT REPLACEMENT	YES	NO	IF YES, WHAT JOINT AND WHEN_____
CANCER	YES	NO	IF YES, WHEN AND WHAT TYPE_____

DO YOU HAVE A CONDITION, ILLNESS OR OTHER MEDICAL CONDITION NOT DISCUSSED ABOVE? YES NO

IF YES, PLEASE LIST CONDITION(S):_____

DO YOU SUFFER FROM CLICKING OR POPPING IN YOUR JAW? YES NO EXPLAIN_____

HAVE YOU EVER HAD TO HAVE ANTIBIOTIC PREMED IN THE PAST FOR JOINT REPLACEMENT OR HEART CONDITIONS? YES NO

DO YOU SMOKE CIGARETTES (INCLUDING E-CIGARETTES) ON A DAILY BASIS? YES NO

IF YES, HOW MUCH IN A DAY?_____

DO YOU USE SMOKELESS TOBACCO ("SNUFF" OR "CHEW") ON A DAILY BASIS? YES NO

IF YES, HOW MUCH IN A DAY?_____

DO YOU CONSUME ALCOHOL ON A DAILY BASIS? YES NO

IF YES, HOW MUCH IN A DAY?_____

DO YOU CURRENTLY USE OR HAVE USED IN THE PAST COCAINE, MARIJUANA, METHAMPHETAMINE, HEROIN, OR OPIOIDS FOR RECREATIONAL PURPOSES IN THE PAST 12 MONTHS? YES NO

ARE YOU CURRENTLY BEING TREATED OR HAVE BEEN TREATED IN THE PAST FOR DRUG ADDICTION? YES NO

ARE YOU CURRENTLY TAKING (OR HAVE IN THE PAST) SUBOXONE, SUBUTEX, VIVITROL, SUBLOCADE OR METHADONE? YES NO

DO YOU CONSUME SUGARY DRINKS (e.g."SODA", "POP", "SPORTS DRINKS"," JUICE")? YES NO

IF YES, HOW MUCH AND HOW OFTEN ON A DAILY BASIS?_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING: PLEASE CIRCLE ALL THAT APPLY

CODEINE SULFA PENICILLIN LATEX LOCAL ANESTHETIC OTHER_____

ARE YOU OR COULD YOU CURRENTLY BE PREGNANT? YES NO IF YES, WHEN IS YOUR DUE DATE_____

ARE YOU CURRENTLY BREASTFEEDING? YES NO

PLEASE LIST <u>ALL MEDICATIONS</u>, INCLUDING OVER THE COUNTER MEDICINES. IT IS VERY IMPORTANT WE KNOW ALL MEDICATIONS AS THEY CAN INTERFERE WITH DENTAL ANESTHETICS (NUMBING MEDICATION).

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PATIENT SIGNATURE (GUARDIAN) DATE

REVIEWED BY:_____ DATE:_____