Confidential Health History

Do you have a personal physician? ☐ Yes ☐ No
Physicians Name:____________________
Address:____________________
Street City State Zip
Phone#: (___)__________ Date of Last Visit:_______
Your Current Physical health is: ☐ Good ☐ Fair ☐ Poor
Please explain:____________________
Are you currently under the care of a physician? ☐ Yes ☐ No
____
Have there been any changes to your health within the last year?____________________

For Women: Are you:
Taking Birth Control? ☐ Yes ☐ No
Pregnant? ☐Unsure ☐ Yes ☐ No
Week #:_______ Are you nursing? ☐ Yes ☐ No

Previous Dental Office: ____________________
Do you have any problems with prior dental treatment?
____
Are you experiencing any dental pain?______________

Are you allergic to any of the following?

Y N Aspirin
Y N Barbiturates
Y N Codiene
Y N Darvon
Y N Dental Anesthetics
Y N Demoral
Y N Erythromycin
Y N Food
Y N Latex
Y N Metal
Y N Nitrous Oxide
Y N Penicillin
Y N Percodan
Y N Sulfa Drugs
Y N Tetracycline
Y N ValiumY N
Y N Vicodin
Y N Other

Please list additional drugs/materials that cause allergic reactions:____________________

Are you taking or have you taken any of the following in the last three months?

Y N Acetaminophen
Y N Alcohol
Y N Antibiotics
Y N Aspirin
Y N Blood Thinners
Y N Blood Pressure Meds.
Y N Digitalis/Heart Med
Y N Fosamax (Bisphosphonate)
Y N Insulin/ Diabetes Drugs
Y N Nitroglycerin
Y N Over the Counter Meds.
Y N Recreational Drugs
Y N Steroids/ Cortisone
Y N Supplements
Y N Thyroid Medicine
Y N Tobacco in any form
Y N Tranquilizers
Y N Weight Loss Medications

Are you taking any prescription/over the counter drugs not listed above? ☐ Yes ☐ No If yes, please list each one:____________________

Do you or have you experienced the following?

Y N Abnormal Bleeding
Y N Alcohol Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones/Joints
Y N Artificial Valves
Y N Asthma
Y N Autoimmune disease
Y N Blood Transfusion
Y N Bleeding Problems
Y N Blood in Urine/Stool
Y N Blurred Vision
Y N Cancer
Y N Cold Sores
Y N Chemotherapy
Y N Chest Pain (angina)
Y N Chicken Pox
Y N Chronic Pain
Y N Congestive Heart Failure
Y N Congenital Heart Defect
Y N Cosmetic Surgery
Y N Diabetes
Y N Dizziness
Y N Drug Abuse
Y N Dry Mouth
Y N Eating Disorder/Malnutrition
Y N Emphysema
Y N Epilepsy
Y N Excessive Thirst
Y N Eye Disease
Y N Fainting Spells
Y N Fever Blisters
Y N Frequent Urination
Y N Gastrointestinal Disease
Y N Glaucoma
Y N Headaches
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes
Y N High Blood Pressure
Y N HIV+/AIDS
Y N Hospitalized for any Reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Osteoporosis
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Scarlet Fever
Y N Seizures
Y N Sexually Transmitted Disease
Y N Shortness of Breath
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Stroke
Y N Thyroid Disease
Y N Tuberculosis
Y N Ulcers

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ Yes ☐ No

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ Yes ☐ No
Please explain:____________________

Is there any condition you would like to discuss with the dentist privately? ☐ Yes ☐ No

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease? ☐ Yes ☐ No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcernia or skeletal complications resulting from Paget's disease, Multiple myeloma or metastatic cancer? ☐ Yes ☐ No