Health History for Family Dentistry of Seneca

Patient Name:_____ DOB:_____

I. CIRCLE APPROPRIATE ANSWER (leave blank if you do not understand the question):

1 Is your general health good? YES NO

2 Has there been a change in your health within the last year? YES NO

3 Have you been hospitalized or had a serious illness in the last three years? YES NO

If YES, why? _____

4 Are you under the care of a physician? YES NO Name:_____ Phone:_____

5 Have you had problems with prior dental treatment?_____

II. ARE YOU/HAVE YOU/DO YOU:

6 Taking Blood Thinners? YES NO
(Coumadin, Plavix, aspirin, etc.) _____

7 Allergic to penicillin or other antibiotics? YES NO

8 Allergic to Latex? YES NO

9 Have a pacemaker? Placed:_____ YES NO

10 Use Tobacco products? Please specify:_____ YES NO
_____

11 Experienced any bleeding problems? YES NO
(hemophilia, clotting deficiencies, etc.)

12 Taking medication for osteoporosis? (Fosamax, Boniva, Aredia, Zometa, Reclast, Actonel, etx.) YES NO

13 Sensitive to dental anesthetics? YES NO

14 Drink alcohol? How much/How often?_____ YES NO

15 Use recreational drugs? What type?_____ YES NO

III. HAVE YOU/DO YOU:

16 Possess a medical condition that requires antibiotics prior to dental treatment? YES NO

17 Had any total joint replacements? If yes, date(s) placed:_____ YES NO

18 Had any organ transplants or been told you are immune compromised? If yes, date(s)_____ YES NO

19 Have a damaged heart valve? YES NO

20 Had a prosthetic heart valve or repair with a prosthetic material? If yes, date(s)_____ YES NO

21 Been told you have a congenital heart abnormality? YES NO

22 Rheumatic fever? YES NO

IV. HAVE YOU EXPERIENCED:

23 Chest pain (angina)? YES NO

24 Shortness of breath? YES NO

25 Bleeding problems, bruising easily? YES NO

26 Persistent cough, coughing up blood? YES NO

27 Difficulty swallowing? YES NO

28 Frequent vomiting, nausea? YES NO

29 Dizziness or fainting spells? YES NO

30 Ringing in ears? YES NO

31 Chronic headaches? (# per week)_____ YES NO

32 Dry mouth? YES NO

V. DO YOU HAVE/HAVE YOU HAD:

33 Heart disease? YES NO

34 Heart attack(s)? Year(s)_____ YES NO

35 High blood pressure? YES NO

36 Stroke? YES NO

37 Asthma, TB, Emphysema, other lung diseases? YES NO

38 Hepatitis, other liver disease? YES NO

39 Diabetes? YES NO

40 HIV/AIDS? YES NO

41 Cancer, chemotherapy, radiation? YES NO

42 Arthritis, rheumatism? YES NO

43 Skin disease? YES NO

44 VD (syphilis, gonorrhea, herpes)? YES NO

45 Kidney, bladder disease? YES NO

46 High Cholesterol? YES NO

VI. WOMEN ONLY:

48 Is there any chance that you may be pregnant? YES NO

49 Are you nursing? YES NO

VII. ALL PATIENTS:

50 Please list any other allergies that you have (drugs, metals, cats/dogs,etc.):_____

51 Please list any over-the-counter medications or herbal supplements that you take:_____

52 Please list any medicines that you are currently prescribed, including birth control pills:_____

53 Do you have or have you had any other diseases or medical problems NOT listed on this form? YES NO

If so please explain:_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform the dentist of any change to my health and or medication.

Patient's Signature (Parent if minor)_____**Date:**_____