YOUR HEALTH HISTORY

Today's Date:_____

As a health-centered practice we are concerned with your total well being. Please answer all of the questions as completely as possible as all questions have relevance to your oral health. If you have any questions and/or need assistance you are welcome to contact our office. ***Thank you!***

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Mayo Clinic #: _____

Name of Physician and Clinic: _____ Physician's Phone:_____

Whom may we contact in case of an emergency? _____ Contact's Phone:_____

Any changes in your health in the past year? _____Yes _____No If so, how? _____

Are you under a physician's care now? _____Yes _____No Why? _____ Height _____ Weight _____

Please list current medications and dosages: prescription or non-prescription (including birth control, Aspirin, Blood thinning medications, vitamins, herbals, etc.) **Bring in/attach additional sheet if necessary.**_____

_____

Are there any medication(s) prescribed by your physician that you are not taking? _____Yes _____No

LIST OF CONDITIONS

Please select if you have or have had any of the following **{also - circle any option(s) that pertain within various brackets}:**

- ❑ Heart Issues **{Heart Attack, Heart Disease, Heart Surgery, Valve Prolapse, Murmur, etc}**
- ❑ Shortness of breath w/o exercise or when lying down
- ❑ High/Low Blood Pressure
- ❑ Cognition Issues **{Stroke, Fainting Spells, Convulsions, Epilepsy, Seizure}**
- ❑ Artificial Body Parts **{Joints_____, heart valve, other prosthesis ____, other body implant ____ }**
- ❑ Psychiatric or Eating Disorder Issues **{Anxiety, Depression, Anorexia, Bulimia, other}**
- ❑ Kidney Issues
- ❑ Bone Issues **{Osteoporosis, Osteopenia, Other}**
- ❑ Do you consume alcohol? _____ Yes _____ No
  How many drinks per week?_____
- ❑ OB/GYN
  {Currently Pregnant or Nursing or Birth Control Pill use}
- ❑ Glaucoma **{Wide Angle, Narrow A., Other}**
- ❑ Cancer **{Surgery, Chemotherapy, Radiation}**
- ❑ Chest Pain, Pressure or Tightness
- ❑ Swelling of Feet/Ankles/Hands
- ❑ Lung Issues **{TB, Asthma, Emphysema, other}**
- ❑ Liver Issues **{Hepatitis – Type ( ), Yellow Jaundice, other}**
- ❑ Blood Issues **{anemia, leukemia, transfusion, bleeding tendency after surgery, other}**
- ❑ Substance Abuse (pain pills or other - describe)_____
  {Past concern now well managed, ongoing current concern}
- ❑ Diabetes
- ❑ AIDS or HIV Positive
- ❑ Have you ever smoked? _____ Yes _____ No
  Do you smoke now? _____ Yes _____ No
  On average: How many years total did/have you smoked? ____
  On average: Number of packs/day ____
- ❑ Are you interested in quitting? _____ Yes _____ No
- ❑ Smokeless Tobacco? _____ Current _____ Past
- ❑ Marijuana or other recreational drug use?
- ❑ Myasthenia Gravis?

- ❑ Are you allergic to or have you had any reactions like stomach upset to the following:
  ❑ Novocaine or other dental anesthetics ❑ Penicillin ❑ Other antibiotics ❑ Codeine ❑ Sedatives ❑ Iodine ❑ Aspirin
  ❑ Latex ❑ Any metals {eg. Nickel (costume jewelry), mercury, etc.} ❑ Foods:_____ ❑ Hay Fever ❑ Other_____

Is there anything else that would be valuable for us to know about your health? _____ Yes _____ No (Please list) _____

_____

Have you ever had any other serious illness, hospitalization, or surgical operation of any kind? _____ Yes _____ No

Bring in/attach additional sheet if necessary. (Describe)_____

_____

Have you ever been told to take an antibiotic ("Premedicate") prior to dental visits? _____ Yes _____ No

Do you still take this "Premedication" antibiotic prior to dental visits? _____ Yes _____ No

I hereby certify that the forgoing information is correct. If there are any changes in my medical record I will notify my dentist. I also authorize the dental office to perform those procedures necessary to accomplish the agreed upon treatment. Also, I authorize the release of my records as deemed necessary.

Patient/Guardian Signature:_____ Date:_____