American Family Dental Care
Implant Center and Cosmetic Dentistry

HEALTH HISTORY FORM

Name: Date:

Date of last health care exam: What was this exam for?

Have you been hospitalized in the last 5 years? Yes ☐ No ☐

If yes, reason:

Are you currently reciving care? Yes ☐ No ☐

If yes, nature of care:

Please list all the names and phone numbers of the physicians who are currently providing you care:

1.
2.
3.
4.

Anemia or Blood Disorder	NO	YES	Hepatitis, any from?	NO	YES
Arthritis, Rheumatism or other Inflammatory disease	NO	YES	Joint Replacement When placed?	NO	YES
Abnormal Bleeding from a cut	NO	YES	Kindney disease	NO	YES
Cancer or Tumor	NO	YES	Liver disease	NO	YES
Diabetes	NO	YES	Psychosis	NO	YES
Emphysema or Respiratory/ Lung Illnesses?	NO	YES	Previous Biopsies	NO	YES
			Radiation or Chemotherapy	NO	YES
Epilepsy	NO	YES	Rheumatic fever	NO	YES
Fainting or Dizzy spells	NO	YES	Slow-Healing mouth sores	NO	YES
Glaucoma	NO	YES	Unintentional weight loss or gain	NO	YES
Abnormal Heart or previous bacterial endocarditis	NO	YES	H.I.V infection/ AIDS or ARC	NO	YES
Heart Valve (artificial) or Heart Transplant?	NO	YES	Venereal Diseases	NO	YES
			Other conditions	NO	YES
Congenital heart disease	NO	YES	Recurrent Illnesses	NO	YES
Heart disease, heart attack, heart surgery	NO	YES			
Heart stent? When placed?	NO	YES			

Doyou take any of the following medications?

Pre-medication with antibiotic before dental treatment?	NO	YES	Tagamet (cimetedine), Prilosec(omeprazole) Antacids?	NO	YES
Pre-medication with anti-anxiety medication before dental treatment	NO	YES	Cardizem(diltiazem) or Calan, Isoptin?	NO	YES
			Serzone (nefazodone)	NO	YES
			Diflucan (fluconazole) or Sporonax(itraconcole)	NO	YES
Dilantin or Tegretol	NO	YES	Biaxin (clarithromycin)	NO	YES
Barbiturates (any)	NO	YES			
St. John`s Wort or Kava-Kava?	NO	YES			

Have you ever been treated with Biophosphonate drugs? (Fosamax, Aredia, Zometa, Actonel, Bonivia?	NO	YES
If so, when did the treatment begin?		
Have you ever taken any prescribtion drugs such as fen-phen for weight-loss?	NO	YES
Do you consume grapefruit juice, grapefruits or grapefruite extract?	NO	YES

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Please list any medications, vitamins, or herbal supplements you are takiing and for what purpose

Medication or Sepplement	Reson you are taking it	Doctor`s use

Women:

Is there a chance you are pregnant?	NO	YES
If no, are you planing a pregnancy in the near future?	NO	YES
Are you a nursing mother?	NO	YES
Are you taking birth control pills?	NO	YES

Abnormal Blood pressure?	NO	YES
Have you ever received a diagnosis of " high blood pressure"?	NO	YES
What is your normal blood pressure? S /D	Today:	

Are you allergic or have you had a reaction to:

1. local anesthetics	NO	YES
2. Penicillin or other antibiotics	NO	YES
3. Aspirin, Ibuprofen or Tylenol	NO	YES
4. Codeine, Valium, or other sedatives	NO	YES
5. Latex or Metal	NO	YES
6. Other(please specify):		

Tobacco, Alchohol, Drugs

Do you use tobacco? If yes, please circle type: smoke chew How much per day ? For how long?		
Do you want to quit using tobacco?	NO	YES
Do you consume alchohol? If yes, approximately how many alchoholic beverages per week?	NO	YES
Do you use any mood altering drugs other than those previously listed?	NO	YES

Weight and Diet Considrations

Weight	Meals per day	Dietry Restrictions	Food allergies
Sugar in your diet (circle one): none slight moderate high			

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Doctor`s use only

Comments on patient`s interview concerning medical history:

Significant findings from interview concerning or oral interview:

Dental management considerations:

I understand the above information is necessary to provide me with dental care in a safe efficint manner. I have answered all the questions to the best of my knowledge. Should further information be needed, you have any permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

Patient (print name)	Patient signature	Date

ASA	Doctor`s signature	Date