Health Information Form

Patient's Name: _____ Date of Birth: _____ Last Physical Date: _____

Physician's Name & Phone #: _____

Reason for today's visit: _____

Work Related Injury? (Circle) **Yes No** Have you been under the care of a physician? (Circle) **Yes No**

Date of last Dental visit: _____ Have you ever been hospitalized? (Circle) **Yes No** Date of most recent hospitalization: _____

Date of last dental x-rays : _____ Ever had Novacaine or other local anesthetic? (Circle) **Yes No**

Are you interested in tooth whitening? (Circle) **Yes No** Do you use any tobacco products? If **Yes**, what kind? _____

If wearing dentures, age of dentures: _____ Are you interested in new dentures? **Yes No**

Are you taking or have taken any steroid/cortisone therapy in the last 2 years? (Circle) **Yes No**

Are you taking or have taken Oral Bisphosphonates, e.g., **FOSAMAX, ACTONEL, BONIVA**, or IV bisphosphonates, e.g., **ZOMETA**, **AREDIA**? (Circle) **Yes No**
Taken for how long? _____

Have you taken antibiotic premedication prior to dental procedures in the past due to artificial joints (knee, hip, etc) artificial heart valve, history of endocarditis etc.? (Circle) **Yes No**

Have you had an adverse reaction to or become ill to penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? (Circle) **Yes No**

List any medications you are allergic to: Do you have a Latex allergy? **Yes No**

1. _____ 2. _____ 3. _____ 4. _____

List any medications you are taking including non-prescription drugs including herbals/vitamins:

1. _____ 2. _____ 3. _____ 4. _____

Do you have a history of:	**Y**	**N**		**Y**	**N**		**Y**	**N**
Anemia			Epilepsy or Seizure, Fainting Spells			Mitral Valve Prolapse		
Arthritis/Gout			Excessive Bleeding			Pain in Jaw Joints		
Artificial Joint			Frequent Headaches/Migraines			Psychiatric Care		
Artificial Valve			Heart Attack/Failure			Radiation Treatment		
Aspirin/Anticoagulant Therapy			Heart Murmur			Rheumatic Fever		
Asthma			Heart Pace Maker			Sinus Trouble		
Blood Transfusion			Hepatitis A, B, or C (Circle)			Stroke		
Bone Medication			High or Low Blood Pressure (Circle)			Thyroid Disease		
Breathing Problem			HIV Positive/ AIDS			Tuberculosis		
Cancer {_____}			Kidney Problems			Ulcers		
Diabetes			Liver Disease			Venereal Disease		
Drug Addiction			Lung Disease			Other Disease or illness		

Women	Y	N		Y	N
Is there a possibility of Pregnancy?			Are you Nursing?		
Estimated Delivery Date: / /			Are you taking any birth Control prescriptions?		
NOTE: **Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.**					

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge.

_____ Date _____
Patient's Signature

_____ Date _____
Dr's Signature/Medical History Review