HEALTH HISTORY

Patient Name_____ **Birthdate**_____

Physician's Name_____ **Dr's Phone #**_____

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

Please answer the following questions as complete as possible. (Circle YES or NO)

MEDICAL HISTORY

1. Do you consider yourself to be in good heath?	YES	NO
2. Are you now or have you been under a physician's care within the past year? If yes, specify condition being treated:_____	YES	NO
3. Do you take any medications, including birth control pills? Please specify name and purpose of medications:_____	YES	NO
4. Have you ever taken Phen-Fen or similar appetite suppressants?	YES	NO
5. Have you ever taken Biphosphonate medications (Fosamax, Boniva, Actonel, Reclast, Didronel, Aredia, Zometa, Bonefos)? These medications are administered for the treatment of osteoporosis, Paget's Disease, and cancer.	YES	NO
6. Do you have or have you ever had any heart or blood problems?	YES	NO
7. Have you ever been told that you have a heart murmur?	YES	NO
8. Do you require antibiotic pre-medication for a heart condition, artificial valve or artificial joint?	YES	NO
9. Do you have or have you ever had high blood pressure?	YES	NO
10. Do you bleed or bruise easily?	YES	NO
11. Have you ever been diagnosed as being HIV positive or having AIDS?	YES	NO
12. Have you ever had hepatitis or liver disease?	YES	NO
13. Have you ever been treated for cancer?	YES	NO
14. Have you ever had: Rheumatic fever____; Arthritis____; Asthma____; Diabetes____; Hepatitis____; Rheumatism____; Tuberculosis____; Venereal Disease____; Heart Attack____; Kidney Disease____; Immune System Disorders____; Other? Please specify_____	YES	NO
15. Are you subject to fainting?	YES	NO
16. Have you ever received counseling for excessive use of alcohol and/or prescription drugs?	YES	NO
17. Have you ever had an unusual reaction or are you allergic to any medications or substances? Aspirin____; Penicillin____; Acetominophen____; Ibuprofen____; Codeine____; Barbituates____; Sulfa Drugs____; Acrylic____; Metal____; Latex Rubber____; Other_____	YES	NO
18. Are you on a special diet?	YES	NO
19. Women: are you pregnant?	YES	NO
20. Have you ever had any other serious illness not listed above? _____	YES	NO

DENTAL HISTORY

21. Are you now in pain?	YES	NO
22. How long ago did you last see a dentist? _____		
23. Who was your previous dentist?_____		
24. Do you like your smile? Why?_____	YES	NO
25. Are you allergic to any local anesthetic?	YES	NO
26. D you think your teeth are affecting your general health in any way?	YES	NO
27. Do you have or have you ever had bleeding or sensitive gums?	YES	NO
28. Do you use or have you ever used tobacco or alcohol?	YES	NO
29. Do you have a specific dental problem?_____	YES	NO
30. Do you have dry mouth?	YES	NO
31. Do you have jaw joint pain or clicking?	YES	NO
32. Do you grind your teeth?	YES	NO

I hereby certify that the answers to the foregoing questions are accurate to the best of my ability. Since a change in my medical history or in medications I take can affect dental treatment, I understand the importance of and agree to take responsibility to notify the dentist of any changes at any subsequent appointment.

_____ Date_____

Patient Signature or Parent / Guardian

In accordance with the Federally mandated HIPAA Act, I acknowledge that a "Notice of Privacy Practices" was made available to me by Rosewood Professional Center.

_____ Date_____

Patient Signature or Parent / Guardian