HEALTH HISTORY FORM

Today's Date: ______________________ E-Mail: ____

Patient Name: _____________________________________ Preferred Name: __________________________

Date of Birth: _____/_____/_____ (MM/DD/YYYY) Social Security No.: _______________________

Cell Phone: _____________________ Home Phone: ___________________ Business Phone: _________________

Address: ____
City/State Zip Code

Family Status: Married ____ Single ____ Child ____ Other _____

Emergency Contact: ____
Name Relationship Phone #

Are you completing this form for someone else? YES NO If yes, what is your relationship: __________________

COMMUNICATION

Would you like to receive dental appointment reminders by text and/or e-mail?	YES	NO
May we leave personal/medical/billing information on your voicemail/answering machine?	YES	NO
May we call you on your home/cell phone regarding personal/medical/billing information?	YES	NO

Do you have any of the following diseases or problems: (DK = Don't Know answer to question)

Active Tuberculosis? ____ (Y/N/DK)

Persistent cough great than 3 weeks? ____ (Y/N/DK)

Cough that produces blood? ____ (Y/N/DK)

Been exposed to anyone with Tuberculosis? ____ (Y/N/DK)

If you've answered YES to any of the above questions, please stop and return to the Front Desk.

Has a physician or dentist recommended taking antibiotics before dental treatment? YES NO

Have you had a **JOINT** replacement? Y / N If yes, what joints, and when? ____

Were you told to take an antibiotic before dental appts? ___ Have you had related complications? ___

Have you had a **HEART VALVE** replacement? Y / N If yes, when? ____

Were you told to take an antibiotic before dental appts? ___ Have you had related complications? ___

What is the name of your Orthopedic Surgeon or Cardiologist? ____

Do you have any other disease, condition, or problem not listed that we should know about? Y / N

If yes, please explain: ____

Note: both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

[The remainder of this page is left intentionally blank]

Medical Information

<table>
<tr><td>Are you in good health? YES NO
Have you had changes in your general health within the past year? YES NO
If yes, what condition is being treated?</td><td></td><td>Do you drink alcoholic beverages? YES NO
How much in last 24 hours? ______________
How much in a typical week? ____________</td><td></td></tr>
<tr><td>Are you under the care of a physician? YES NO
Physician Name:
Phone:</td><td></td><td>Do you use tobacco (smoking, snuff, chew, bidis)?
If so, are you interested in stopping? ___
Do you use any type of e-cigarette? ___</td><td></td></tr>
<tr><td>Date of last physical exam?</td><td></td><td>Do you use controlled substances (drugs) for recreational purpose? ___</td><td></td></tr>
<tr><td>Are you taking, or recently have taken any prescription or over the counter medicine(s)?</td><td></td><td></td><td></td></tr>
<tr><td>Are you, or have you taken, any diet drugs such as Pondimin (fenflluramine), Redux (dexphenfluramine), or phen-fen (fenflluramine-phentermine combination)? ___
Please specify: ___________________________</td><td></td><td rowspan="2">WOMEN ONLY
Are you pregnant? _____
Number of weeks: _____
Are you nursing? ______
Are you taking birth control or hormone replacement? ______</td><td></td></tr>
<tr><td>Are you taking or scheduled to begin taking either of the medications, alendronate (Fosomax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? ___</td><td></td><td></td></tr>
<tr><td>Since 2001, were you treated or are you presently scheduled to begin treatment with intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?
Date to begin treatment: __________________</td><td></td><td rowspan="3">ALLERGIES
Latex --Y N DK
Penicillin ------------------------------------Y N DK
Other antibiotics ----------------------------Y N DK
Local anesthetics ---------------------------Y N DK
Sulfa drugs ----------------------------------Y N DK
Aspirin ---------------------------------------Y N DK
Codeine --------------------------------------Y N DK
Other narcotics -----------------------------Y N DK
Barbiturates, sedatives, or sleeping pills -Y N DK
Metals ---------------------------------------Y N DK
Iodine --Y N DK
Hay fever/seasonal -------------------------Y N DK
Animals -------------------------------------Y N DK
Food ---Y N DK
Other: ___________________________________</td><td></td></tr>
<tr><td>Have you had a serious illness, operation or been hospitalized in the past 5 years?
If yes, what was the illness/problem?
____
____
____</td><td></td><td></td></tr>
<tr><td>Please list all medications, including vitamins (natural/herbal) and/or diet supplements:
____
____
____
____
*Please provide a list if there is not enough space</td><td></td><td></td></tr>
</table>

Angina: Y / N / DK	Rheumatic heart disease: Y / N / DK	Emphysema: Y / N / DK
Anemia: Y / N / DK	Low blood pressure: Y / N / DK	Epilepsy: Y / N / DK
Pacemaker: Y / N / DK	High blood pressure: Y / N / DK	Sinus trouble: Y / N / DK
Arteriosclerosis: Y / N / DK	Stroke: Y / N / DK	Kidney problems: Y / N / DK
Blood transfusion: Y / N / DK	Coronary artery disease: Y / N / DK	Diabetes (Type I or II) Y / N / DK
Chest pain upon exertion: Y / N / DK	Congenital heart defects: Y / N / DK	Chronic Pain: Y / N / DK
Mitral valve prolapse: Y / N / DK	Fainting spells: Y / N / DK	Sexually Trans. Disease: Y / N / DK
Abnormal bleeding: Y / N / DK	Seizures: Y / N / DK	HIV / AIDS: Y / N / DK
Artificial heart valve: Y / N / DK	Osteoporosis: Y / N / DK	Hepatitis: Y / N / DK
Heart attack: Y / N / DK	Asthma: Y / N / DK	HPV: Y / N / DK
Cardiovascular disease: Y / N / DK	Thyroid problems: Y / N / DK	Ulcers: Y / N / DK
Congestive heart failure: Y / N / DK	Arthritis: Y / N / DK	Sleep apnea: Y / N / DK
Heart Murmur: Y / N / DK	Bronchitis: Y / N / DK	Rheumatoid arthritis: Y / N / DK
Hemophilia: Y / N / DK	Glaucoma: Y / N / DK	ADHD: Y / N / DK
Persistent swollen glands in neck: Y / N / DK	Autoimmune disease: Y / N / DK	Severe headaches or migraines: Y / N / DK
Mental Disorders: (circle all that apply) Anxiety, Bipolar, Depression, Eating disorders, Schizophrenia, Alcohol/Substance abuse/addiction	Recurrent infections: Specify:	Neurological disorders: Specify:

I certify that I have read and understand the above, and the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_______________________________ _______________________________

Patient/Guardian Signature Date