PATIENT HEALTH HISTORY INFORMATION

The following information is essential for this office to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to meet your dental needs safely and efficiently.

Incorrect information can be dangerous to your health.

Date: 6/19/2019

Patient Name (Last, First, MI): Test, Patient

Birth Date 10/1/1970 (MM/DD/YYYY)

MEDICATIONS - Please list all prescription and over the counter medicines or provide a list for us to copy, including vitamins, natural and herbal preparations and/or diet supplements:

☐ Please check this box if you are taking additional medications not listed here, and bring a list along to your appointment.

ALLERGIES - Select all that apply:

☐ Local Anesthetic ☐ Aspirin, Tylenol, NSAIDs ☐ Penicillin Allergy ☐ Other Antibiotics ☐ Sulfa Allergy

☐ Barbiturates, Sedatives or Sleeping Pills ☐ Latex Allergy ☐ Iodine Allergy ☐ Hay Fever / Seasonal

☐ Codeine, Hydrocodone, Other Narcotics ☐ Metals Allergy ☐ Food Allergy

☐ Other Allergy:

SELECT THE APPROPRIATE ANSWER

			If yes:
Have you ever been told by a medical or dental provider not to take over the counter or prescription medications and/or supplements?	☐ No	☐ Yes	
Have you EVER taken or are you currently taking any medications for Osteoporosis/Osteopenia (low bone density)?	☐ No	☐ Yes	
Are you taking any blood thinner medications?	☐ No	☐ Yes	
In the past 12 months, have you taken steroids (Ex. Prednisone)?	☐ No	☐ Yes	

COMMENTS:

DO YOU HAVE OR HAVE YOU EVER HAD:

	No	Yes	If Yes:
Artificial (Prosthetic) Heart Valve	☐	☐	
Previous Infective Endocarditis	☐	☐	
Congenital Heart Disease (CHD)	☐	☐	
Cardiovascular Disease	☐	☐	
Angina	☐	☐	
Arteriosclerosis	☐	☐	
Congestive Heart Failure	☐	☐	
Damaged Heart Valves	☐	☐	
Heart Attack	☐	☐	
Heart Murmur	☐	☐	
Heart Stents	☐	☐	
Stroke	☐	☐	
Low Blood Pressure	☐	☐	
High Blood Pressure	☐	☐	
Mitral Valve Prolapse	☐	☐	
Heart Pacemaker	☐	☐	
Rheumatic Heart Disease	☐	☐	
Abnormal Bleeding or Blood Disorder	☐	☐	
Anemia	☐	☐	
Blood Transfusion	☐	☐	
HIV or AIDS Infection	☐	☐	
Arthritis/Rheumatoid Arthritis	☐	☐	
Autoimmune Disease	☐	☐	
Respiratory/Lung Problems	☐	☐	
Asthma	☐	☐	
Bronchitis	☐	☐	
Emphysema	☐	☐	
Sinus Trouble	☐	☐	
Cancer	☐	☐	
Chemotherapy	☐	☐	

DO YOU HAVE OR HAVE YOU EVER HAD (continued):

	No	Yes	If Yes:
Radiation Therapy	☐	☐	
Chest Pain Upon Exertion	☐	☐	
Chronic Pain	☐	☐	
Tuberculosis	☐	☐	
Diabetes - Type I or II If yes, enter type and last HbA1c in text box.	☐	☐	
Eating Disorder	☐	☐	
Gastrointestinal Disease	☐	☐	
G.E. Reflux/Persistent Heartburn	☐	☐	
Ulcers	☐	☐	
Thyroid Problems	☐	☐	
Glaucoma If yes, enter Narrow or Wide in text box.	☐	☐	
Retinal Detachment	☐	☐	
Hepatitis, Jaundice or Liver Disease	☐	☐	
Epilepsy	☐	☐	
Fainting Spells or Seizures	☐	☐	
Neurological Disorders	☐	☐	
Sleep Disorder	☐	☐	
Mental Health Disorder	☐	☐	
Recurrent Infections	☐	☐	
Kidney Problems	☐	☐	
Osteoporosis / Osteopenia	☐	☐	
Bone or Joint Problems	☐	☐	
Organ Transplant	☐	☐	
Persistent Swollen Glands in Neck	☐	☐	
Severe Headaches/Migraines	☐	☐	
Severe or Rapid Weight Loss	☐	☐	
Sexually Transmitted Disease	☐	☐	

Has a physician or previous dentist recommended that you take antibiotics for heart or joint related conditions prior to your dental treatment? ☐ No ☐ Yes If yes:

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Have you had a total or partial orthopedic joint replacement (Hip, knee, shoulder, ankle or other)?

☐ No ☐ Yes

If yes: Date of Placement:

If yes, have you had complications/repeat surgery on the same joint?

Do you use recreational drugs? ☐ No ☐ Yes If yes:

Do you use tobacco? ☐ No ☐ Yes If yes, select one: ☐ Smoke Tobacco ☐ Smokeless Tobacco

Amount per day:

Do you have hearing problems, hearing aids or surgical implant?

☐ No ☐ Yes If yes:

Have you ever had a serious injury to your head, neck or teeth?

☐ No ☐ Yes If yes:

Have you ever had an operation? ☐ No ☐ Yes If yes:

Do you have a disease, condition, or problem not listed on this health history?

☐ No ☐ Yes If yes:

Are you taking birth control? ☐ No ☐ Yes If yes:

Are you pregnant? ☐ No ☐ Yes If yes:

Are you breast feeding? ☐ No ☐ Yes If yes:

ADDITIONAL COMMENTS:

To the best of my knowledge, the questions on this form have been answered correctly.

Note: A change in your health status should be reported to the office at the earliest possible time. The patient, parent or guardian has read and understands the policies of the office and hereby consents to treatment on that basis.

Patient or Legal Guardian Name:

Relationship to Patient:

By signing this form, I certify that the above information is true and correct to the best of my knowledge.

Patient or Legal Guardian Signature (Use Stylus to Sign on Screen):

Date (MM/DD/YYYY)

Waukon Dental 6/19/2019 9:53:53 AM