HEALTH HISTORY

ENDODONTIC AND IMPLANTOLOGY ASSOCIATES

Patient Name: ______________________________

CIRCLE APPROPRIATE ANSWER

Date of last physical exam: ____ /____ /____ Date of last dental exam: ____ /____/____

YES NO Has there been a change in your health within the last year?
YES NO Have you been hospitalized or had serious illness in the last three years?
YES NO If YES, why? ______________________________
YES NO Are you being treated by a physician now? For what? ______________________________
YES NO Do you have dental phobia?
YES NO Do you have difficulty getting numb?
YES NO Would you like the doctor to discuss anti-anxiety (sedation) options with you?
YES NO Do you require an antibiotic prior to dental appointments for a medical reason (ie. joint replacement, heart condition, other)?

HAVE YOU RECENTLY EXPERIENCED

YES NO Shortness of breath
YES NO Recent weight loss, fever, night sweats
YES NO Persistent cough, coughing up blood
YES NO Bleeding problems, bruising easily
YES NO Sinus problems
YES NO Difficulty swallowing
YES NO Diarrhea, constipation, blood in stools
YES NO Headaches
YES NO Fainting spells
YES NO Seizures
YES NO Dry mouth
YES NO Jaundice
YES NO TMJ (Jaw Joint Problems)

DO YOU HAVE OR HAVE YOU HAD

YES NO Heart disease
YES NO Heart attack, heart defects
YES NO Heart murmur
YES NO Rheumatic fever
YES NO Stroke, hardening of arteries
YES NO Abnormal blood pressure S_____ / D_____
YES NO Asthma, TB, emphysema, other lung diseases
YES NO Hepatitis, other liver disease
YES NO Stomach problems, ulcers
YES NO Colitis
YES NO Allergies to: drugs, foods, medications, latex
Please list: ______________________________
YES NO HIV/AIDS
YES NO Tumors, cancer
YES NO Skin diseases
YES NO Anemia
YES NO Herpes
YES NO Kidney, bladder disease
YES NO Thyroid, adrenal disease
YES NO Diabetes, type? ________

DO YOU HAVE OR HAVE YOU HAD

YES NO Psychiatric care
YES NO Radiation treatments
YES NO Chemotherapy
YES NO Prosthetic heart valve
YES NO Artificial joint, when placed? __________
YES NO Blood transfusions
YES NO Pacemaker
YES NO Contact lenses

ARE YOU TAKING

YES NO Recreational drugs
YES NO Prescription medications, over-the-counter medications, (including aspirin or natural remedies)
Please list: ______________________________
YES NO Tobacco in any form, type? __________
YES NO Alcohol, how often? ______________
YES NO Are you currently taking or have you previously taken a bisphosphonate medication, such as Actonel, Fosamax or Zometa?

WOMEN ONLY

YES NO Are you or could you be pregnant or nursing?
YES NO Taking birth control pills?

ALL PATIENTS

YES NO Do you have or have you had any other diseases or medical problems NOT listed on this form?
____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

✗ Patient's Signature: ______________________________ Date: ____/____/____

Reviewed by: ______________________________ Date: ____/____/____