HEALTH HISTORY INFORMATION

Patient Name _____ Date _____

Health problems that you may have, or medications you are taking (including herbal or over-the-counter), could have an important impact on the care that you will receive and your oral health. Thank you for answering the following questions as accurately as possible.

Are you in good health? ☐ Yes ☐ No Any changes in your general health in the last year? ☐ Yes ☐ No If yes, explain: _____

_____

Yes	No	
☐	☐	Are you under the care of a physician? Physician's Name _____ Date of last visit? _____
☐	☐	Have you had a heart valve replacement or vascular graft? If yes, what and when? _____
☐	☐	Have you had a joint replacement? If yes, what area? _____ Month & Year done_____
☐	☐	Have you ever been advised by your physician to take "Pre-Medication" antibiotics prior to dental treatment?
☐	☐	Have you ever taken a bisphosphonate medication? (Bone density meds such as Fosamax, Actonel, Boniva, Atelvia, Didronel)
☐	☐	Have you ever taken any diet pill drugs referred to as "fen-phen" or similar (fenfluramine/phentermine) ? (Some common names are: Redux, Ionimin, Adipex, Fastin, Pondimin, and others)
☐	☐	Are you currently taking any blood thinner medications (such as Coumadin, Plavix, Aspirin, Xarelto, Eliquis, etc.)
☐	☐	Have you ever had any problems with general or local anesthesia? ☐ Yes ☐ No If yes, explain : _____

_____

For Women Only:

- Possibility of pregnancy? ☐ Yes, currently pregnant Due Date? _____ ☐ Possibly pregnant ☐ Not pregnant
- Are you currently nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

Do you have, or have you had any of the following? Mark "Yes" or "No" to all diseases, medical conditions, or procedures.

Yes	No	
☐	☐	Artificial Joints - where? _____
☐	☐	Acid Reflux
☐	☐	AIDS
☐	☐	Anemia
☐	☐	Anxiety
☐	☐	Arthritis/Rheumatism
☐	☐	Asthma
☐	☐	Blood Disease
☐	☐	Blood Transfusion
☐	☐	Bronchitis/Chronic Cough
☐	☐	Bruise easily
☐	☐	Cardiac Pacemaker
☐	☐	Cancer – type _____
☐	☐	Chemotherapy
☐	☐	Chemical Dependency – drugs/alcohol
☐	☐	Diabetes-type _____
☐	☐	Difficulty Breathing
☐	☐	Dizziness or Fainting
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Excessive Bleeding
☐	☐	Eye Disease–specify _____
☐	☐	Hay Fever
☐	☐	Heart Attack(s) - when? _____
☐	☐	Heart Disease - specify _____
☐	☐	Heart Murmur
☐	☐	Heart Surgery - when? _____
☐	☐	Headaches
☐	☐	Hepatitis - type? _____
☐	☐	Herpes
☐	☐	High Blood Pressure
☐	☐	HIV
☐	☐	Immune System Problems
☐	☐	Jaw Pain/Clicking/Popping
☐	☐	Jaundice
☐	☐	Kidney Disease
☐	☐	Liver Disease
☐	☐	Low blood pressure
☐	☐	Low blood sugar
☐	☐	Mental Disorders
☐	☐	Mitral Valve Prolapse
☐	☐	Osteoporosis or Osteopenia
☐	☐	Pneumonia
☐	☐	Respiratory problems
☐	☐	Rheumatic Fever
☐	☐	Scarlet Fever
☐	☐	Sexually transmitted disease
☐	☐	Sinus problems
☐	☐	Sleep Apnea/Use a CPAP
☐	☐	Smoker-cigarettes, pipe, cigar?
☐	☐	Snoring
☐	☐	Stroke
☐	☐	Thyroid Disease
☐	☐	Tuberculosis
☐	☐	Ulcers - type? _____
☐	☐	Use chewing tobacco

Any other medical condition not listed above?

_____

ALLERGIES

Do you have allergies or sensitivities to any of the following?

Yes	No		Yes	No	
☐	☐	Penicillin drugs	☐	☐	Local Anesthetic
☐	☐	Sulfa drugs	☐	☐	Latex
☐	☐	Erythromycin drugs	☐	☐	Metals
☐	☐	Other Antibiotics	☐	☐	Any other drugs?
☐	☐	Codeine			Specify_____
☐	☐	Aspirin	☐	☐	Any other substances?
☐	☐	NSAIDS			Specify_____

*Non-steroidal anti-inflammatories

MEDICATIONS

Please list all medications, including herbal supplements & over the counter meds you are currently taking and dosage or provide a copy of your meds list:

Medication **Dosage**

_____

_____

_____

_____

_____

I certify that all of my health information is complete and accurate to the best of my knowledge. I understand that if there is a change in my health or medication(s) during my dental treatment, I am responsible for updating Maryam Jackson, D.D.S. and/or her Staff as to those changes.

Patient Signature _____ **Date** _____