OFFICIAL USE ONLY

Pre-Med YES NO ____________________
LATEX YES NO ______________________
Allergies ____________________________
Comments: ___________________________

Downtown Dental

Your smile. Our tradition

HEALTH HISTORY

To ensure your well being while undergoing treatment in our office, please answer the following questions in detail. All information will be considered confidential and for our records only.

Patient Name_________________________________ Birthdate___________________ Today's Date_____________

Previous Dentist's Name and Address ____________________________________Dentist's Phone__________________

Physician's Name and Address ____ Physician's Phone _______________

Date of your most recent visit to Physician and Reason _____________________ _____________________________

How would you assess your general Health? Good Fair Poor How would you assess your dental health? Good Fair Poor

Your normal blood pressure BP: ________Pulse: _______ Weight________Pregnant________ Due Date___________

ALLERGIES

Are you **allergic** (hives, rash, swollen eyes,trouble breathing, etc.) to or been advised to not take any of the following:

	Yes	No		Yes	No
Antibiotics (penicillin, tetracycline, etc .)	[ ]	[ ]	Aspirin	[ ]	[ ]
Local Dental Anesthetics (novacaine)	[ ]	[ ]	Barbituates or Sedatives	[ ]	[ ]
Codeine or narcotics	[ ]	[ ]	Latex	[ ]	[ ]
Ibuprofen (Advil, Motrin, NSAIDS)	[ ]	[ ]	Acetominophen	[ ]	[ ]
Seasonal Allergies	[ ]	[ ]	Animals	[ ]	[ ]
Metals	[ ]	[ ]	Sulfa	[ ]	[ ]
Food	[ ]	[ ]	Iodine	[ ]	[ ]

Others ____ Comments________________________________

Do you take medications for these allergies? [ ] Yes [ ] No Medication?____________________________

Have you ever had an adverse reaction like nausea, dizziness, or feeling "spacey" with any drug or medication?

Please explain:____

	Yes	No
1. Are you seeing a physician at the present time for the treatment of a recent or ongoing medical condition? If yes, explain:____	[ ]	[ ]
2. Have you been hospitalized within the last year? If yes, explain:____	[ ]	[ ]
3. Have you had a serious illness or operation within the last year? If yes, explain: ____	[ ]	[ ]
4. Have you ever had any serious medical trouble associated with any dental experience? If yes, explain: ____	[ ]	[ ]
5. Have you ever been advised to take antibiotics (like penicillin, etc.,) before a dental appointment? If yes, explain: ___________________________ Physician recommending _______________________________	[ ]	[ ]

Active Tuberculosis [ ] Yes [ ] No Persistent cough lasting more than three weeks [ ] Yes [ ] No

Cough that produces blood [ ] Yes [ ] No Exposed to someone with tuberculosis [ ] Yes [ ] No

If you answered yes, to any of these four questions. Please stop and return this form to the receptionist.

Patient Name___________________________

Today's date___________________________

Health History Continued

Please indicate if you have or have had any of the following diseases or problems?

CARDIOVASCULAR

High Blood Pressure YES [ ] NO [ ] Low Blood Pressure YES [ ] NO [ ] Cardiovascular Disease YES [ ] NO [ ]

Check any that apply: [ ] hardening of arteries [ ] bypass surgery [ ] stroke [ ] high cholesterol [ ] murmur [ ] heart attack [ ] mitral valve prolapse [ ] congestive heart failure [ ] Pacemaker When Placed? ___________ [ ] angina [ ] rheumatic fever or heart disease [ ] arrhythmias [ ] fainting spells [ ] chest pain upon exertion

Except for the four conditions listed below, antibiotic prophylaxis is no longer recommended for any other form of CHD

[ ] prosthetic heart valve[ ] infective endocarditis [ ] cyanotic CHD [ ] transplant damaged valves

Medication type and amount prescribed for above? ____

____

PULMONARY

COPD YES [ ] NO [ ] Asthma YES [ ] NO [ ] Emphysema YES [ ] NO [ ] Other____________________

Check any that apply: [ ] Shortness of breath after mild exertion [ ] Swollen ankles [ ] Sinus trouble [ ] Difficulty breathing when reclined [ ] Snoring [ ] Sleep apnea [ ] Pneumonia [ ] TB

Medication type and amount prescribed for above? ____

____

BLOOD

Abnormal bleeding or extended clotting time YES [ ] NO [ ] Hemophilia YES [ ] NO [ ] Anemia [ ] YES [ ] NO

Sickle Cell Disease YES [ ] NO [ ] AIDS/HIV YES [ ] NO [ ] Hepatitis YES [ ] NO [ ] Type A ____ B____ C___

Liver disease YES [ ] NO [ ] Blood transfusion YES [ ] NO [ ] Date of transfusion? ________________

Medication type and amount prescribed for above? ____

____

JOINT

Have you ever had an orthopedic joint replacement? [ ] Yes [ ] No Which and When? __________________________

OTHER

	Yes No		Yes No		Yes No	
Alzheimer's Disease	[ ] [ ]	Diabetes	[ ] [ ]	Type 1 __ Type 2__Insulin type and dose______________		
Arthritis	[ ] [ ]	Eating disorder	[ ] [ ]	Mental	[ ] [ ]	Specify:______________________
Autoimmune Disease	[ ] [ ]	Epilepsy or	[ ] [ ]	Neurologic	[ ] [ ]	Specify:______________________
Cancer	[ ] [ ]	Gastric Reflux	[ ] [ ]	Glaucoma	[ ] [ ]	
Chemo/Radiation	[ ] [ ]	Headaches	[ ] [ ]	Kidney	[ ] [ ]	
Cirrhosis	[ ] [ ]	Organ Transplant	[ ] [ ]	Parkinson's	[ ] [ ]	
Depression	[ ] [ ]	Osteoporosis	[ ] [ ]	Thyroid	[ ] [ ]	

Other(s) :____

Medication type and amount prescribed for above? ____

____

Others meds currently taking, amount and dose?____

Have the oral health risks ever been explained? **Smoking** [ ] Yes[ ] No **Smokeless tobacco use** [ ] Yes [ ] No **Excessive alcohol consumption** [ ] Yes [ ] No **Oral piercings** [ ] Yes [ ] No **Illegal drugs** [ ] Yes [ ] No

Patient or Guardian Signature	Printed Name	Date
______________________________	______________________________	__________