

# ENDODONTIC AND IMPLANTOLOGY ASSOCIATES

## HEALTH HISTORY

Patient Name: \_\_\_\_\_

### CIRCLE APPROPRIATE ANSWER

- 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 Date of last physical exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of last dental exam: \_\_\_\_/\_\_\_\_/\_\_\_\_  
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 Have you been recommended by your medical doctor to take an antibiotic prior to dental appointments?

### HAVE YOU RECENTLY EXPERIENCED

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

### DO YOU HAVE OR HAVE YOU HAD

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

### DO YOU HAVE OR HAVE YOU HAD

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

### ARE YOU TAKING

- |     |    |  |     |    |                                  |
|-----|----|--|-----|----|----------------------------------|
| YES | NO | Recreational drugs   | YES | NO | Tobacco in any form, type? _____ |
| YES | NO | Prescription medications, over-the-counter medications,<br>(including aspirin or natural remedies)                     | YES | NO | Alcohol, how often? _____        |
|     |    | Please list: _____   |     |    |                                  |
| 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.

**X** Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_