Modern Dental Concepts

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HEALTH HISTORY INFORMATION

Name: ____ Date: ________________________

Address: ____

Date of birth: ________________________ Sex (circle): Male Female

Social Security Number: ____

Concerns regarding your mouth/teeth today: ____

For the following questions, circle yes or no. Your answers are for our records only and will be considered confidential.

1. Are you in generally good health? …………………….…………………………………….…... YES NO
2. Has there been any change since your last visit ………………………………………………..… YES NO
3. Date of your last physical exam: _____/_____/_______ (if exact date is not know, please list year)
4. Are you being treated by your physician for any specific condition? ..………………………..…... YES NO

   If yes, please list: ____

5. Name and address of your physician: ____

   ____

   ____

6. Have you had any serious illnesses, operations or hospitalizations in the past 5 years? .... YES NO

   If yes, please list: ____

7. Do you have any artificial joints/implants? ………………………………………………………... YES NO

   If yes, please list type & date of placement _____________________________________

8. Are you taking any medication? (including non-prescription, homeopathic or "natural" remedies) …… YES NO

   If yes, please list: ____

   ____

   ____

9. Are you taking any of the following medications?

   a) Aspirin, Motrin, other anti-inflammatory medication …………………………………….. YES NO
   b) Coumadin, Plavix, Lovenox, other blood-thinner …………………………………….... YES NO

c) Vitamin E, Ginigo Biloba, Ginseng, Garlic pills ………………………………………. YES NO

d) Aminoglycoside derivatives (Gentamicin, Streptomycin, etc.) ………………………... YES NO

Bisphosphonates or Osteoporosis Medications

a) Fosamax, Actonel, Boniva, Aredia …………………………………………………….. YES NO

b) Zometa (Zoledronate), Didronel (Etidronate), Skelid (Tiludronate) …………………… YES NO

10. Do you have or have you had any of the following diseases or problems?

a) Damaged heart valves, artificial valves or heart murmur………………………………. YES NO

b) Rheumatic Heart disease………………………………………………………………... YES NO

c) Heart attack, high blood pressure, stroke, arteriosclerosis, other heart condition ……… YES NO

d) Low blood pressure……………………………………………………………………. YES NO

e) Seasonal allergies………………………………………………………………………. YES NO

f) Sinus issues……………………………………………………………………………... YES NO

g) Asthma or hay fever ……………………………………………………………………. YES NO

h) Respiratory problems, emphysema, bronchitis, etc……………………………………. YES NO

i) Tuberculosis…………………………………………………………………………… YES NO

j) Fainting spells or seizures………………………………………………………………. YES NO

k) Epilepsy or any other neurological disorder……………………………………………. YES NO

l) Diabetes…………………………………………………………………………………. YES NO

m) Hepatitis, jaundice, or liver disease……………………………………………………... YES NO

n) Kidney trouble………………………………………………………………………….. YES NO

o) Thyroid problem………………………………………………………………………… YES NO

p) Arthritis or painful/swollen joints (including TMJ)……………………………. …… YES NO

q) Stomach ulcer or hyperacidity…………………………………………………………. YES NO

r) Cancer………………………………………………………………………….……. YES NO

s) Any disease, drug or transplant operation that suppresses your immune system……… YES NO

t) Skin disease……………………………………………………………………………. YES NO

u) Mental illness/Psychiatric disorders…………………………………………………… YES NO

v) AIDS/HIV ……………………………………………………………………..……. YES NO

w) Other STI/STD …………………………………………………………….…………..…. YES NO

11. Have you ever had a blood transfusion? ………………………………………………….. YES NO
12. Do you have a blood disorder, such as anemia? .... YES NO
13. Have you ever had treatment for a tumor or a growth? .... YES NO
14. Are you allergic to any of the following?
    a) Local anesthetic…………………………………………………………………... YES NO
    b) Penicillin or other antibiotics……………………………………………………... YES NO
    c) Sulfa drugs…………………………………………………………………………... YES NO
    d) Barbiturates or sleeping pills……………………………………………………... YES NO
    e) Aspirin………………………………………………………………………………. YES NO
    f) Iodine……………………………………………………………………………….... YES NO
    g) Codeine……………………………………………………………………………… YES NO
    h) Latex………………………………………………………………………………… YES NO
    i) Eggs/egg protein…………………………………………………………………….. YES NO
    j) Birds/bird protein……………………………………………………………………. YES NO
    k) Other, please list: ____
15. Do you smoke or use tobacco products? ……………………………………………………. YES NO
16. Do you consume alcoholic beverages? ……………………………………………………… YES NO
17. Have you ever received radiation treatment to your head or neck? …………………………… YES NO
18. Have you had eye surgery within the past year? ………………………………………………. YES NO
19. Have you had any serious trouble associated with previous dental treatment? ……………….. YES NO
    If yes, please explain: ____
20. Do you have any other condition/disease you think the doctor should know about? ………… YES NO
21. Are you wearing contact lenses? ……………………………………………………………. YES NO
22. Are you wearing a removable dental appliance? ……………………………………………. YES NO
23. Do you wish to talk to the doctor privately about anything? ………………………………….. YES NO
24. Do you have a strong gag reflex? ……………………………………………………………. YES NO
25. Do you have difficulty breathing through your nose? ………………………………………….. YES NO
26. Have you had dental work at another location in the past year? ……………………………….. YES NO
    If yes please explain: ____

WOMEN

27. Are you pregnant? ………………………………………………………………………………. YES NO
28. Are you nursing? ……………………………………………………………………………… YES NO
29. Do you have any problems associated with your period? ………………………………………. YES NO
30. Are you taking any birth control pills (oral contraceptives)? ………………………...………. YES NO

Taking any un-prescribed or illegal drugs may seriously interfere with the medications used in anesthesia, and may ultimately lead to death. Please advise the doctor if you have used any such drugs in the past especially within the past 48 hours.

I certify that I have read and understand the above. I acknowledge that any questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold Modern Dental Concepts or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: ______________________________ Date: ____________________

For completion by the doctor:

Comments on patient interview concerning medical history: ______________________________

____

Significant findings from questionnaire: ______________________________________

____

Doctor Signature: ______________________________ Date: ____________________