

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: _____