Modern Dental Concepts

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HEALTH HISTORY INFORMATION

Patient Name: ____ Age: ____________________

Concerns regarding your mouth/teeth today: ____

For the following questions, circle yes or no

1. Are you in generally good health? …………………………………………………………… YES NO
2. Has there been any change since your last visit ……………………………………………… YES NO
3. Are you being treated by your physician for any specific condition? ………………………… YES NO
   If yes, please list: ____
4. Name and address of your physician: ____
   ____
5. Date of your last physical exam: ______/______/________
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? (include 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?**
    - ☐ AIDS/HIV
    - ☐ Any disease/drug/operation suppressing your immune system
    - ☐ Arthritis or painful joints (TMJ)
    - ☐ Asthma or hay fever
    - ☐ Bronchitis
    - ☐ Cancer – type: ____________________
    - ☐ Damaged heart valves/artificial valves
    - ☐ Diabetes
    - ☐ Emphysema
    - ☐ Epilepsy or other neurological disorder
    - ☐ Fainting spells or seizures
    - ☐ Heart attack
    - ☐ Heart condition other: ______________
    - ☐ Heart murmur
    - ☐ Hepatitis, jaundice, or liver disease
    - ☐ High blood pressure
    - ☐ Low blood pressure
    - ☐ Kidney trouble
    - ☐ Mental illness
    - ☐ Other STI/STD
    - ☐ Respiratory problems
    - ☐ Rheumatic heart disease
    - ☐ Seasonal allergies
    - ☐ Sinus issues
    - ☐ Skin disease
    - ☐ Stomach ulcer or hyperacidity
    - ☐ Stroke
    - ☐ Thyroid problem
    - ☐ Tuberculosis

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?
    - ☐ Aspirin
    - ☐ Birds/bird protein
    - ☐ Codeine
    - ☐ Eggs/egg protein
    - ☐ Iodine
    - ☐ Latex
    - ☐ Local anesthetic
    - ☐ Penicillin or other antibiotics
    - ☐ Sulfa drugs
    - ☐ Other: ___________________________
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 a removable dental appliance? ……………………………………………. YES NO
22. Do you wish to talk to the doctor privately about anything? ………………………………….. YES NO
23. Do you have a strong gag reflex? ……………………………………………………………. YES NO
24. Have you had dental work at another location in the past year? ……………………………….. YES NO
    If yes please explain: ____

WOMEN

25. Are you pregnant? ………………………………………………………………………. YES NO
26. Are you nursing? …………………………………………………………………………. YES NO
27. 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.

Signature: ____ Date: ____________________

(IF MINOR) Parent/Guardian Name: ____

For completion by the doctor:

Comments on patient interview concerning medical history: ______________________________

____

Significant findings from questionnaire: ____

____

Doctor Signature: ______________________________________ Date: ____________________