

HEALTH HISTORY

Name: _____ Date: _____

Address: _____ City _____ State _____ Zip _____

Phone numbers: Home: _____ Work: _____ Cell: _____

Email: _____ Marital status: Married ___ Single ___ Divorced ___ Other ___

Male ___ Female ___ Date of Birth _____ Age _____ Social Security # (for insurance purposes only) _____

HOW CAN WE HELP YOU TODAY?: _____

How did you learn about our office: (Please check one)

___ Friend or Relative: _____ ___ Star Banner ___ Yellow Pages ___ On Top of The World
 ___ Driving by office ___ Web Page: www.harterdental.com Other: _____

Date of last health care exam: _____ Date of last Dental Exam: _____ Last Dental Cleaning: _____

Name, location, phone number for Preferred **Pharmacy:** _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

1. Artificial heart valve	No	Yes	Heart attack (When) _____	No	Yes
2. History of infective endocarditis	No	Yes	Myocardial infarct (When) _____	No	Yes
3. Congenital heart conditions (birth defects): repaired or incompletely repaired cyanotic disease, prosthetic repair, remaining defect after repair	No	Yes	High or low blood pressure	No	Yes
			Pacemaker (What Kind) _____	No	Yes
			Heart stent (When) _____	No	Yes
			Stroke: (When) _____	No	Yes
4. Cardiac transplant with heart valve problem	No	Yes			
History of prolonged use of Morphine	No	Yes	Treated for Anxiety	No	Yes
Treated for Chronic Pain Management	No	Yes	Treated for Depression	No	Yes
History of recreational drug use (Confidential)	No	Yes	Treated for Psychosis	No	Yes
Daily consumption of Grapefruit Juice	No	Yes	Treated for Hyperactivity	No	Yes
Asthma	No	Yes	Latex Allergy	No	Yes
Diabetes	No	Yes	Joint Replacement (When?) (What kind?)	No	Yes
Hepatitis, Any Form	No	Yes	Previous Biopsies	No	Yes
Liver disease (including Jaundice)	No	Yes	Slow-Healing Mouth Sores	No	Yes
Kidney disease	No	Yes	Abnormal Bleeding from a cut	No	Yes
Anemia (blood disease)	No	Yes	Glaucoma	No	Yes
Emphysema or other Respiratory Illnesses	No	Yes	Sinus trouble	No	Yes
Epilepsy	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
HIV Positive or AIDS Related Complex	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Venereal Disease	No	Yes	Recurrent Illnesses	No	Yes
Hypertension	No	Yes	Other Infections:	No	Yes
G.E.R.D. or Gastric Reflux or Ulcers	No	Yes	Radiation or Chemotherapy	No	Yes

Are you taking any of these medications:

Pre-medication before dental treatment?	No	Yes	Tagamet (Cimetidine)?	No	Yes
Antacids?	No	Yes	Herbal Supplements?	No	Yes
Warfarin or Coumadin?	No	Yes	Other:	No	Yes
Have you been treated with Biophosphonate drugs? Fosamax, Boniva or Actonel				No	Yes

Please list any **medications or supplements** you are currently taking?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Have you been hospitalized in the last 5 years? (Please circle)

No Yes

If yes, reason: _____

Are you currently receiving medical care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

- 1. _____ 2. _____
- 3. _____ 4. _____

Women: Are you pregnant?

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (Please circle)

If yes, what is it usually? S _____ /D _____ No Yes

Are you allergic or have you had a reaction to any of the following. Please circle and/or specify:

- a. Local anesthetics No Yes
- b. Penicillin or other antibiotics No Yes
- c. Aspirin No Yes
- d. Codeine, valium or other sedatives No Yes
- e. Other _____ No Yes

Are you a smoker?

If so, how much do you smoke per day? _____ No Yes

Do you consume grapefruit juice, grapefruits or grapefruit extract?

No Yes

Average Weight: _____

Diet: Restricted Diet: _____

How many meals a day? _____

Food Allergies: _____

Sugar in your diet: None Slight Moderate High

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of changes in my health and medication.

Patient (Print Name) Patient Signature Date

Dentist (Print Name) Dentist Signature Date