WNCDental Health History2.4.14c

Patient Name: Birth Date: Date Created:

Required Health History

Many health condition or medications can affect your oral health or dental treatment safety. Please answer all the questions to the best of your knowledge.

Are you in poor health? (If yes, any changes to your health in the past year and if you are under the	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs? Please list them:	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux? (weight loss drugs)	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	If yes
Do you use tobacco?	Yes No	If yes
Do you have any artificial joints such as a knee, hip, etc? If yes, what year were they placed?	Yes No	If yes
Do you have any (circle) Artificial Heart Valve, damaged Heart Transplant, previous Endocarditis,	Yes No	
Do you take aspirin daily or other prescription blood thinners?	Yes No	If yes

Do you use controlled substances?	Yes No	If yes

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Females Note: Certain antibiotics can affect the efficacy of oral contraceptives. Additional

ARE YOU ALLERGIC to any medicine, drug, food, material or any environmental substance? If yes,	Yes No	If yes
Have you ever had any serious illness not listed	Yes No	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Recent Weight Loss	Yes No	Anaphylaxis	Yes No
Drug Addiction	Yes No	Hepatitis A, B or C	Yes No	Renal Dialysis	Yes No	Anemia	Yes No
Easily Winded	Yes No	Rheumatic Fever	Yes No	Angina	Yes No	Emphysema	Yes No
High Blood Pressure	Yes No	Rheumatism	Yes No	Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No
High Cholesterol	Yes No	Scarlet Fever	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No
Shingles	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No	Breathing Problems	Yes No
Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No	Bruise Easily	Yes No
Low Blood Pressure	Yes No	Swelling of Limbs	Yes No	Cancer	Yes No	Glaucoma	Yes No
Lung Disease	Yes No	Thyroid Disease	Yes No	Chemotherapy	Yes No	Mitral Valve Prolapse	Yes No
Tonsillitis	Yes No	Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No
Tuberculosis	Yes No	Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No
Tumors or Growths	Yes No	Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No
Ulcers	Yes No	Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No
Yellow Jaundice	Yes No	Alcoholism	Yes No	Lupus	Yes No	Hearing Problems	Yes No

Dental History

Do you have concerns about your mouth or teeth?	Yes No	If yes
Has it been a while since your last dental checkup?	Yes No	If yes
Have you ever had any bad reactions to dental anesthetics (numbing)?	Yes No	If yes

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist or his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form and I will inform the doctor and staff immediately of any changes to my health or medications.

Signature of Patient, Parent or Guardian:

X_____ Date:_____

Dentist Signature

Dentist's Authorized Medical History Review Electronic Signature In Comment Box: omment