HEALTH HISTORY

Advanced SEDATION DENTISTRY

PATIENT INFORMATION

Legal Name | DOB

Home Phone

Reason for seeking treatment:

MEDICAL DOCTOR'S INFORMATION

Doctor's Name

Street | Ste#

City | State | Zip

Doctor's Phone

MEDICAL QUESTIONNAIRE

Please check the appropriate answer and elaborate as needed. Your answers are confidential and for our records only.

Are you in good health? ☐ Yes ☐ No
Are you currently under medical care? ☐ Yes ☐ No
*If so, what condition is being treated?*_____
When was your last physical exam_____
Has there been any change to your health within the past year? ☐ Yes ☐ No
Have you ever had a serious illness or operation? ☐ Yes ☐ No
Have you ever had any abdominal bleeding after an accident, surgery, or having a tooth pulled? ☐ Yes ☐ No
Have you ever had a blood transfusion? ☐ Yes ☐ No
Have you ever had surgery or x-ray (radiation) treatment for a tumor, growth, or other condition? ☐ Yes ☐ No

Do you have or have you ever had any of the following:

Rheumatic fever or rheumatic heart disease ☐ Yes ☐ No
Heart abnormalities present since birth ☐ Yes ☐ No
Heart murmur ☐ Yes ☐ No
Mitral valve prolapse ☐ Yes ☐ No
Artificial joint prosthesis ☐ Yes ☐ No
High blood pressure ☐ Yes ☐ No
Heart attack or stroke ☐ Yes ☐ No
Bypass surgery ☐ Yes ☐ No
Pacemaker / defibrillator ☐ Yes ☐ No
Angina (Chest pain) ☐ Yes ☐ No
Congestive heart failure ☐ Yes ☐ No
AIDS / HIV ☐ Yes ☐ No
Anemia, sickle cell anemia, or other bleeding disorder ☐ Yes ☐ No
Asthma ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
If Yes, what kind: _____
Diabetes ☐ Yes ☐ No
Drug or alcohol abuse ☐ Yes ☐ No
Epilepsy, seizures, or fainting spells ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No
Hepatitis or liver disease ☐ Yes ☐ No
Kidney disease ☐ Yes ☐ No
If Yes, do you receive dialysis? ☐ Yes ☐ No
Lung disease ☐ Yes ☐ No
Stomach ulcers ☐ Yes ☐ No
Thyroid problems ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No
Venereal disease ☐ Yes ☐ No

Was there any disease, condition, or problem not listed? ☐ Yes ☐ No
If Yes, please explain: _____

List any previous surgeries, procedures, or anesthetics:

1. _____ Date_____
2. _____ Date_____
3. _____ Date_____
4. _____ Date_____

Are you taking any of the following:

Antibiotics ☐ Yes ☐ No
Blood thinners (Coumadin, Warfarin, Aspirin) ☐ Yes ☐ No
High blood pressure medication of any kind ☐ Yes ☐ No
Steroids (Cortisone, Prednisone) ☐ Yes ☐ No
Aspirin or NSAID's (Motrin, Advil, etc…) ☐ Yes ☐ No
Dilantin or any other anti-seizure medication ☐ Yes ☐ No
Nitroglycerin ☐ Yes ☐ No
Narcotics ("Pain pills") ☐ Yes ☐ No
Birth control pills of any kind ☐ Yes ☐ No
Alcohol ☐ Yes ☐ No
Recreational drugs of any kind ☐ Yes ☐ No
Was there any medication not listed? ☐ Yes ☐ No
If Yes, please specify: _____

Are you a smoker? ☐ Yes ☐ No
If Yes, how many years?: _____ *How many packs a day?*_____
Are you allergic or have you ever reacted adversely to:
Local anesthetics (Novocaine, etc…) ☐ Yes ☐ No
Penicillin or other antibiotics ☐ Yes ☐ No
If Yes to antibiotics, specify: _____
Aspirin ☐ Yes ☐ No
Codeine or other narcotics ☐ Yes ☐ No
Other_____
Have you had any serious trouble associated with any previous dental treatment ☐ Yes ☐ No
If Yes, please specify: _____

List any current medications and dosages:

1. _____ Dosage _____
2. _____ Dosage _____
3. _____ Dosage _____
4. _____ Dosage _____

Date of your last dental exam:_____

Have you ever been treated for any gum disease like: gingivitis, periodontitis, trenchmouth, pyorrhea ☐ Yes ☐ No
Do your gums bleed when you brush your teeth? ☐ Yes ☐ No
Do you clench your teeth? ☐ Yes ☐ No
Have you had any injuries to your mouth or jaws? ☐ Yes ☐ No
Do you have any sores or swelling of your mouth or jaws? ☐ Yes ☐ No

QUESTIONS FOR WOMEN

Are you or could you be pregnant? ☐ Yes ☐ No
Are you presently breast feeding? ☐ Yes ☐ No

DISCLAIMER

The undersigned patient agrees that all the above information is correct, and has been answered to the best of their knowledge.

_____ _____

Patient (or Parent) Signature | Date | Dentist Signature | Date

Our office is HIPPA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.