CENTERBURG DENTAL CARE

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HEALTH HISTORY FORM

Patient Name _____ Today's Date _____/_____/_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Physician's Name _____

Medications (Or provide separate list) _____

_____

Have you ever had an orthopedic total joint replacement? ☐ Yes ☐ No If yes, date _____

Do you Antibiotic Pre Medicate prior to dental work? ☐ Yes ☐ No

Are you Pregnant? ☐ Yes ☐ No

Are you on Blood thinners? ☐ Yes ☐ No

Have you taken bisphosphonates (bone med IV/Oral)? ☐ Yes ☐ No

ALLERGIES Are you allergic or unable to take any of the following?

Local Anesthetics (used in Dentistry)?	☐ Yes ☐ No	Codeine or other narcotics including Tramadol?	☐ Yes ☐ No
Aspirin / Ibuprofen	☐ Yes ☐ No	Seasonal / Metal / Latex / Animals?	☐ Yes ☐ No
Penicillin or other antibiotics?	☐ Yes ☐ No	Peanuts / Coconuts / Food?	☐ Yes ☐ No
Barbiturates, sedatives or sleeping pills?	☐ Yes ☐ No	Other _____	

Place a mark on "Yes", "No" or "DK (don't know)" to indicate if you have had any of the following:

Abnormal Bleeding ☐ Yes ☐ No ☐ DK	Diabetes Type 1 or 2 ☐ Yes ☐ No ☐ DK	Nervous Problems ☐ Yes ☐ No ☐ DK
AIDS/HIV ☐ Yes ☐ No ☐ DK	Difficutly Laying Flat ☐ Yes ☐ No ☐ DK	Osteoprosis/Osteopenia ☐ Yes ☐ No ☐ DK
Anemia ☐ Yes ☐ No ☐ DK	Eating Disorder ☐ Yes ☐ No ☐ DK	Other Autoimmune Disease ☐ Yes ☐ No ☐ DK
Angina (Chest Pain) ☐ Yes ☐ No ☐ DK	Epilepsy ☐ Yes ☐ No ☐ DK	Periodontal Disease ☐ Yes ☐ No ☐ DK
Arteriosclerosis ☐ Yes ☐ No ☐ DK	Fainting or dizziness ☐ Yes ☐ No ☐ DK	Persistent Swollen Glands ☐ Yes ☐ No ☐ DK
Arthritis, Rheumatism ☐ Yes ☐ No ☐ DK	Glaucoma ☐ Yes ☐ No ☐ DK	Pacemaker ☐ Yes ☐ No ☐ DK
Artificial Heart Valves ☐ Yes ☐ No ☐ DK	Gastrointestinal Disease ☐ Yes ☐ No ☐ DK	Radiation Treatment ☐ Yes ☐ No ☐ DK
Artificial Joints ☐ Yes ☐ No ☐ DK	G.E. Reflux/Heartburn ☐ Yes ☐ No ☐ DK	Recurrent Infections ☐ Yes ☐ No ☐ DK
Asthma ☐ Yes ☐ No ☐ DK	Heart Attack ☐ Yes ☐ No ☐ DK	Specify _____
Bleeding Disorder ☐ Yes ☐ No ☐ DK	Date _____	Respiratory Disease ☐ Yes ☐ No ☐ DK
Blood Transfusion ☐ Yes ☐ No ☐ DK	Heart Murmur ☐ Yes ☐ No ☐ DK	Rheumatic Fever ☐ Yes ☐ No ☐ DK
Bronchitis ☐ Yes ☐ No ☐ DK	Hepatitis Type ☐ Yes ☐ No ☐ DK	Rheumatic Heart Disease ☐ Yes ☐ No ☐ DK
Cancer ☐ Yes ☐ No ☐ DK	Herpes ☐ Yes ☐ No ☐ DK	Severe Headache/Migranes ☐ Yes ☐ No ☐ DK
Cardiovascular Disease/ ☐ Yes ☐ No ☐ DK	High Blood Pressure ☐ Yes ☐ No ☐ DK	Sleep Disorder ☐ Yes ☐ No ☐ DK
Coronary Artery Disease	High Cholesterol ☐ Yes ☐ No ☐ DK	STD ☐ Yes ☐ No ☐ DK
Chemotherapy ☐ Yes ☐ No ☐ DK	Jaundice ☐ Yes ☐ No ☐ DK	Sinus Trouble ☐ Yes ☐ No ☐ DK
Chronic Pain ☐ Yes ☐ No ☐ DK	Jaw Pain ☐ Yes ☐ No ☐ DK	Stents ☐ Yes ☐ No ☐ DK
COPD/Emphysema ☐ Yes ☐ No ☐ DK	Kidney Disease ☐ Yes ☐ No ☐ DK	Stroke ☐ Yes ☐ No ☐ DK
Congenital Heart Defects ☐ Yes ☐ No ☐ DK	Liver Disease ☐ Yes ☐ No ☐ DK	Date _____
Congestive Heart Failure ☐ Yes ☐ No ☐ DK	Low Blood Pressure ☐ Yes ☐ No ☐ DK	Thyroid Problems ☐ Yes ☐ No ☐ DK
Damaged Heart Valves ☐ Yes ☐ No ☐ DK	Lupus ☐ Yes ☐ No ☐ DK	Tuberculosis ☐ Yes ☐ No ☐ DK
Dementia/Memory Loss ☐ Yes ☐ No ☐ DK	Mental Health Disorder ☐ Yes ☐ No ☐ DK	Ulcers/Stomach Troubles ☐ Yes ☐ No ☐ DK
	Specify _____	
	Mitral Valve Prolapse ☐ Yes ☐ No ☐ DK	

Women:

Are you pregnant? ☐ Yes ☐ No Due date: _____ Are you taking birth control pills? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

NOTE: Both Doctor and Patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

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 and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires 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 have made in the completion of this form.

Patient/Guardian Signature _____ **Relationship** _____

Doctor Signature _____