Family & Cosmetic Dentistry
Dental Smiles
At Dacula

Health History Form

Patient Name: _____

There are two ways to your answers to the following questions.
(1) Some questions have options of selecting "YES" or "NO". Answer all such questions by selecting yes or no.
(2) Some questions may have options for you to "Specify Details" if you have entered your response as a "YES" to the specific question. If your response is "NO" to such questions, you may mention "NO" or "Leave blank" the box for response.

1. Are you in good health? Y N
2. Has there been any change in your general health in the past year? Y N
3. Date of last physical exam _____
4. Are you currently under a physician's care for a particular problem, if yes, Please specify details:
_____
5. Have you ever had any serious illness, operations or hospitalizations? If YES, please specify details:
_____
6. Height/ Weight _____

7. DO YOU OR HAVE YOU EVER HAD:

A. Rheumatic Fever or Rheumatic Disease? Y N
B. Congenital Heart Disease? Y N
C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) If YES, please specify.
_____
D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing) If YES, Please specify:
_____
E. Seizures, Convulsion, Epilepsy, Fainting, Dizziness, Psychiatric Treatment or other Nervous Disorder? If YES, please specify: _____
F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? If YOU please specify:
_____
G. Liver Disease (Jaundice, Hepatitis, cirrhosis)? If YES, please specify: _____
H. Kidney Disease, Bladder or Prostate disease? If YES, please specify: _____
I. Diabetes, Type I, Type II, Diabetic complications like retinopathy, neuropathy, and trouble healing of tissues? If YES, please specify: _____
J. Thyroid Disease (Hyperthyroidism, Eurothroidism)? If YES, please specify details:
_____
K. Arthritis (Rheumatoid Arthritis, Osteoarthritis, Degenerative Arthritis)? If YES, Please specify details:
_____
L. Stomach Problems (Ulcers, Reflux), Spleen or Colon related problems? If yes, please specify:
_____
M. Glaucoma? _____
N. Do you have any artificial joints? Implant placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? If YES, please specify details: _____
O. Radiation (X-Ray) treatment for Cancer?
P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? Y N
Q. Sinus or Nasal problems? Y N

R. Any disease, drug or transplant operation that has depressed your immune system? If YES please specify details: _____

S. HIV, AIDS, or ARC? _____

T. Have you ever had any Skin disease, Eye related problems (Glaucoma, retinal defects, etc.) Throat or Neck related disease or surgery? If YES, please specify details: _____

8. ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS

A. Antibiotics? Y N

B. Anticoagulants (Blood Thinners)?

C. Aspirin or drugs such as Motrin, Aleve, ibuprofen? Y N

D. High Blood Pressure medications?

E. Steroids (Cortisone or similar steroids)? If YES, please specify name and reason why you are taking it: _____

F. Tranquilizers? Y N

G. Insulin or Oral Anti-Diabetic drugs? _____

H. Digitalis, Inderal, Nitroglycerin or other heart drugs? _____

I. Any regular prescription medicine, pills or drugs? If YES, please list details: _____

J. Herbal or Holistic remedies, Vitamins or over the counter medications? If YES, please specify details: _____

9. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO?

A. Local Anesthetic (Novocain, etc?) Y N

B. Penicillin or other antibiotics? Y N

C. Sedatives, Barbiturates (Like Valium or similar drugs)? Y N

D. Aspirin or ibuprofen? If YES, please specify: _____

E. Codeine or other pain killers? Y N

F. Latex or Rubber products? _____

G. Other allergies or reactions? If YES, please specify: _____

10. (A) Do you smoke? If yes, please specify quantity per day: _____

10. (B) Do you chew tobacco? If YES please specify quantity per day _____

11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? If YES, please specify details: _____

12. Have you had any serious problems associated with any previous dental treatment? Y N

13. Have you or an immediate family member had any problem with intravenous anesthesia? _____

14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Y N

15. Do you wish to talk to the doctor privately about anything? Y N

16. FEMALES ONLY

A. Are you pregnant or is there any chance you may be pregnant?

B. Are you nursing? Y N

C. If you are using Oral Contraceptives, it is important that you understand that antibiotics (and other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

17. Have you ever been told that you need to be pre-medicated prior to dental procedures? Y N
If yes, please list reason:_____

[ ] I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

Signature: _____ Date: _____