new smiles studio
melanie marshall, dds

Health History Form

Last Name _____ First Name_____ Date of Birth _____

Date of last health care exam: _____What was this exam for? _____

Have you been hospitalized or had surgery? (Select NO or YES) No Yes

If yes, reason: _____

Are you currently receiving 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. _____

For the following questions SELECT NO OR YES.

SELECT NO OR YES	NO	YES	SELECT NO OR YES	NO	YES
Blood Disorders?			Hepatitis, Any Form		
Arthritis, Rheumatism or other inflammatory disease?			Joint Replacement? When placed?		
Asthma, COPD or other Lung Diseases			Kidney Disease		
Abnormal Bleeding from a cut?			Liver Disease (including Jaundice)		
Cancer or Tumor?			Sore/Enlarged Lymph Nodes		
Diabetes			Psychiatric Therapy		
Emphysema or other Respiratory/Lung Illnesses			Previous Biopsies		
Epilepsy			Radiation or Chemotherapy Treatment		
Fainting or Dizzy Spells			Renal Dialysis		
Glaucoma			Slow-Healing Mouth Sores		
Previous Bacterial Endocarditis			Unintentional Weight Loss/Gain		
Heart Valve (artificial) or Heart Transplant			H.I.V. Infection/AIDS or ARC		
Congenital Heart Disease			Venereal Disease		
Heart Disease, Heart Attack, Heart Surgery, Angina			Recurrent Illnesses		
Heart Stent? When placed?			Other Conditions? If yes please specify.		
High blood pressure or low blood pressure? If yes, what is your normal BP?					

Are you taking any of these medications? (SELECT NO OR YES for each question.)

SELECT NO OR YES	NO	YES	SELECT NO OR YES	NO	YES
Pre-medication before dental treatment?			Tagamet® (cimetidine) or Prilosec® (omeprazole)?		
Antacids?			Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?		
St. John's Wort or Kava-Kava?			Serzone® (nefazodone)		
Dilantin® or Tegretol®			Diflucan® (fluconazole) or Sporonox® (itraconazole)		
Barbiturates (any)			Biaxin® (clarithromycin)		
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®, RECLAST) or PROLIA? If so, when did the treatment begin? When did the treatment end?					
Have you ever taken any prescription drugs such as fen-phen for weight loss?					
Do you consume grapefruit juice, grapefruits or grapefruit extract?					

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Women: (SELECT NO OR YES for each question.)

SELECT NO OR YES	NO	YES	SELECT NO OR YES	NO	YES
Are you pregnant?			Are you a nursing mother?		
Are you planning a pregnancy in the near future?			Are you taking birth control pills?		

Are you allergic or have you had a reaction to: (SELECT NO OR YES for each question)

SELECT NO OR YES	NO	YES	SELECT NO OR YES	NO	YES
Local anesthetic or epinephrine?			Codeine, Valium, Hydrocodone, Oxycodone, or other sedatives?		
Penicillin or other antibiotics?			Latex or Metals?		
Aspirin, Ibuprofen or Tylenol?			Other (please specify)		

Tobacco, Alcohol, Drugs: (SELECT NO OR YES for each question)

SELECT NO OR YES	NO	YES
Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long?		
Do you want to quit using tobacco?		
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?		
Do you use any mood altering drugs other than those previously listed?		

Please list any medications, dietary or herbal supplements you are currently taking and dosages:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

DOCTOR'S USE ONLY

Significant findings or dental considerations from questionnaire or oral interview:

_____
_____
_____

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 change in my health and medication. I understand that my answers are for our records only and will be confidential.

_____ _____ _____
Patient (Print Name) *Patient Signature* *Date*

_____ _____ _____
Doctor (Print Name) *Doctor Signature* *Date*