HEALTH HISTORY QUESTIONNAIRE

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DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

- ☐ Rheumatic Fever
- ☐ Rheumatic Heart Disease
- ☐ Heart Murmur
- ☐ Congenital Heart Disease
- ☐ Mitral Valve Prolapse
- ☐ Systemic Lupus
- ☐ Kidney problems
- ☐ Bacterial Endocarditis
- ☐ Heart valve prosthesis
- ☐ Joint prosthesis
- ☐ Cardiac pacemaker
- ☐ Hypertrophic Cardiomyopathy
- ☐ Diabetes
- ☐ Epilepsy/seizure
- ☐ Prolonged bleeding
- ☐ Asthma
- ☐ Arthritis
- ☐ High Blood pressure

INFECTION CONTROL:

- ☐ Hepatitis, when _____
- ☐ Are you a carrier?
- ☐ Cold sores / fever blisters
- ☐ HIV positive: _____
- ☐ AIDS: _____

Other Infections:

ALLERGIES:

- ☐ PCN ☐ Under the care of a physician.
- ☐ SULFA
- ☐ FEN-PHAN
- ☐ LATEX

Other:

OTHER MEDICAL CONDTIONS:

CURRENT MEDICATION:

1. _____ Reason: _____
2. _____ Reason: _____
3. _____ Reason: _____
4. _____ Reason: _____

WOMEN:

- ☐ Are you pregnant?

Trimester 1

Due Date: _____

- ☐ Breast Feeding?

DENTAL - Do you have, or have you had, any of the following:

- ☐ Loose teeth?
- ☐ Sensitive to hot?
- ☐ Sensitive to cold?
- ☐ Sensitive to sweets?
- ☐ Sensitive to biting?
- ☐ Bleeding, sore gums?
- ☐ Unpleasant taste/bad breath?
- ☐ Frequent blisters, lips/mouth?
- ☐ Swelling/lumps in mouth?
- ☐ Biting cheeks/lips?
- ☐ Have you ever had gum disease?
- ☐ Have you ever had periodontal/gum treatment?
- ☐ Have you ever had surgery in your mouth?

When?: _____

PREMEDICATION:

Antibiotic premedication suggested by M.D.? _____

Antibiotic premedication used previously? _____

OTHER DENTAL CONCERNS:

_____

UNDERSTAND THAT THE INFORMATION I PROVIDE ON THIS FORM IS ESSENTIAL TO DETERMINE MY DIAGNOSIS AND THE PROVISIONS OF TREATMENT. I UNDERSTAND THAT IF ANY CHANGE OCCURS IN MY HEALTH I AM TO REPORT IT TO THIS OFFICE AS SOON AS POSSIBLE. I HAVE READ AND UNDERSTAND EACH QUESTION, AND HAVE ANSWERED ALL OF THEM TRUTHFULLY AND TO THE BEST OF MY ABILITY. I HAVE DISCUSSED MY HEALTH HISTORY WITH THIS DOCTOR.

DATE	PATIENT SIGNATURE	DATE	DR. SIGNATURE

(DATE)	(DR INITIALS)	(DATE)	(DR INITIALS)	(DATE)	(DR INITIALS)	(DATE)	(DR INITIALS)