Patient Name_____ DOB_____

General Health History

General health (please check) ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Primary Care Physician_____ Phone_____

Preferred Pharmacy_____ Phone_____

Please check illnesses or conditions you have experienced:

☐ AIDS/HIV
☐ Alcoholism
☐ Allergies
☐ Alzheimer's
☐ Anemia
☐ Angina
☐ Arthritis/Gout
☐ Artificial heart valve
☐ Artificial joint
☐ Asthma
☐ Bleeding problems
☐ Blood disease
☐ Blood transfusion
☐ Breathing problems
☐ Bruise easily
☐ Cancer
☐ Chemotherapy
☐ Cold sores/Fever blisters
☐ Congenital heart disorder
☐ Depression
☐ Diabetes
☐ Dialysis
☐ Drug addiction
☐ Eating disorder
☐ Emphysema
☐ Epilepsy or seizures
☐ Excessive thirst
☐ Fairing spells/Dizziness
☐ Frequent cough
☐ Genital herpes
☐ Glaucoma
☐ Hay fever
☐ Heart defect (including a damaged, repaired or unrepaired valve, cyanotic defect or congenital disease)
☐ Heart murmur
☐ Heart pacemaker
☐ Heart trouble or disease
☐ Hepatitis A, B or C
☐ Herpes
☐ High blood pressure
☐ High cholesterol
☐ Irregular heartbeat
☐ Kidney disease
☐ Leukemia
☐ Liver disease
☐ Low blood pressure
☐ Lung disease
☐ Lupus
☐ Migraines/headaches
☐ Mitral valve prolapse
☐ Organ transplant
☐ Osteoporosis
☐ Paget's disease
☐ Psychiatric care
☐ Radiation treatment
☐ Recent weight loss
☐ Rheumatic fever/disease
☐ Rheumatism
☐ Shingles
☐ Sinus trouble
☐ Stomach/intestinal issues
☐ Stroke/TIA
☐ Swelling limb
☐ Thyroid disease
☐ Tonsilitis
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal disease
☐ Yellow jaundice

Do you have any other health problems or conditions? ☐ Yes ☐ No

If yes, explain_____

Any allergies to: ☐ Penicillin ☐ Codeine ☐ Aspirin ☐ Anesthetics ☐ Valium ☐ Demerol ☐ Latex ☐ Sulfur drugs ☐ Barbiturates ☐ Opiods ☐ Metals ☐ Other _____

Are you taking any blood thinners? ☐ Yes ☐ No If yes, which?_____ Dosage_____
(ex.: rivaroxaban (Xarelto), coumadin (Warfarin), dabigatran (Pradaxa), clopidogrel (Plavix))

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, explain_____

If you have had an orthopedic total joint (hip, knee, etc.) replacement, when? _____

Do you require an antibiotic prior to dental visits? ☐ Yes ☐ No

If yes, why?_____

What antibiotic and what dosage? _____

Are you taking or have you taken oral bisphosphonate or IV medication for osteoporosis or Paget's disease?
☐ Yes ☐ No
(ex.: denosumab (Prolia), alendronate (Fosamax), ibandronate (Boniva), risedronate (Actonel), zolendronate (Reclast))

Female patients: Are you pregnant? ☐ Yes ☐ No Number of months_____
If you have an infant, are you nursing? ☐ Yes ☐ No

Are you currently taking medications? ☐ Yes ☐ No Vitamins/supplements? ☐ Yes ☐ No

List of medications and reason for taking_____

_____

_____

_____

Have you had a serious illness, been hospitalized, or had an operation in the last five years? ☐ Yes ☐ No

If yes, please describe_____

Have you had a serious head/neck injury? ☐ Yes ☐ No If yes, please explain_____

Are you under the care of a specialist? ☐ Yes ☐ No If yes, please explain_____

_____

Name of specialist_____ Phone_____

Do you smoke cigarettes? ☐ Yes ☐ No How many packs/day? _____ For how long?_____

Do you use tobacco products? ☐ Yes ☐ No What product? _____ For how long?_____

Do you vape? ☐ Yes ☐ No How many cartridges/week? _____ For how long?_____

Do you drink alcohol? ☐ Yes ☐ No How many drinks per week? _____

To the best of my knowledge, all of these answers and information provided are true and correct. I will not hold Icon Dentistry PA or its personnel responsible for any complication(s) arising from errors or omissions in this form. If I ever have any changes in my health, I am responsible for informing the doctor and staff at the next appointment.

_____ _____
Signature (patient, parent or guardian) Date

_____
Print name