Health History For Alamo Heights OMS

Patient's Name

Date of Birth

Month Day Year

Date

Month Day Year

Answer All Questions by Indicating Yes or No

All responses will be kept confidential

1. Are you in good health? *

Yes

No

2. Has there been any change in your general health in the past year? *

Yes

No

3. Date of last physical exam

Month, Year

4. Are you under a physician's care for a particular problem? *

Yes

No

5. Have you ever had any serious illnesses, operations, or hospitalizations? If so, describe:

If none, leave blank

6. DO YOU HAVE OR HAVE YOU EVER HAD:

A. Rheumatic Fever or Rheumatic Heart Disease? *

Yes No

B. Congenital Heart Disease? *

Yes No

C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) *

Yes No

D. Lung Disease (Asthma, Bronchitis, Pneumonia, Tuberculosis?) *

Yes No

E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness? *

Yes No

F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? *

Yes No

G. Liver Disease (Jaundice, Hepatitis)? *

Yes No

H. Kidney Disease? *

Yes No

I. Diabetes? *

Yes No

J. Thyroid Disease (Goiter)? *

Yes No

L. Stomach Ulcers or Colitis? *

Yes
No

M. Glaucoma? *

Yes
No

N. Osteoporosis? *

Yes
No

O. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? *

Yes
No

P. Radiation (X-ray) treatment for Cancer? *

Yes
No

Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grinding or clenching of teeth? *

Yes
No

R. Sinus or Nasal problems? *

Yes
No

S. Any disease, drug or transplant operation that has affected your immune system? *

Yes
No

7. ARE YOU USING ANY OF THE FOLLOWING:

A. Antibiotics? *

Yes
No

B. Anticoagulants (Blood Thinners)? *

Yes

No

C. Aspirin or drugs such as Motrin, Aleve, or Ibuprofen? *

Yes

No

D. High Blood Pressure Medications? *

Yes

No

F. Tranquilizers? *

Yes

No

G. Insulin or Oral Anti-Diabetic drugs? *

Yes

No

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

Yes

No

I. Are you taking or have you ever taken Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Fosamax, Actonel, Boniva, Aredia, Zometa)? *

Yes

No

8. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:

A. Local Anesthesia (Novocain, etc.)? *

Yes

No

B. Penicillin or other antibiotics? *

Yes

No

C. Sedatives? *

Yes

No

D. Aspirin or Ibuprofen? *

Yes

No

F. Latex or Rubber Products? *

Yes

No

G. Other allergies or reactions? Please list:

If none, leave blank

9. Do you smoke or chew Tobacco? *

Yes

No

10. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder (PTSD) that may affect the care we provide you? *

Yes

No

11. Have you had any serious problems associated with any previous dental treatment? *

Yes

No

12. Have you or an immediate family member had any problem associated with intravenous (IV) anesthesia? *

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

Yes

No

14. Do you wish to talk to the doctor privately about anything? *

Yes

No

15. FOR WOMEN ONLY

A. Are you Pregnant, or is there any chance you might be Pregnant?

Yes

No

B. Are you Nursing?

Yes

No

16. Other Comments

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible.

Date	Signature of Person Completing Health History	Doctor's Initials

Exceptions or changes	Patient's Signature	Doctor's Initials

Medical Update: I have read my Health History dated _____ and confirm that it adequately states past and present conditions.